Maternal and Child Health Services
Title V Block Grant

State Narrative for Iowa

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

See attachment for Assurances and Certifications.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input was conducted in several different venues this year. A comprehensive method of public input was used for the Title V needs assessment. Stakeholders throughout the state were involved at three different levels. See the needs assessment section for more information.

The needs assessment, state priorities, and proposed state performance measures with activities were posted via the Iowa Department of Public Health Web site.

/2007/ There were approximately 200 hits to the Title V public input section of the Web page. Numerous emails were sent to Title V staff to provide comments on the 2007 application.

The MCH Advisory Council members were asked to assist in the establishment of the Title V priority needs and performance measures. The Council endorsed the state plan at their June 1, 2006 meeting. The members were also asked to provide public comment via the IDPH Web site for the needs assessment and the state performance measures. The Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned about MCH issues. See the attachment for a list of members and by-laws.

The Bureau of Family Health Grantee Committee is comprised of representatives from all 34 local MCH and Family Planning contract agencies. Local contract agencies are encouraged to provide input and influence bureau-related policy and quality assurance activities. Input from the committee was used to determine the Title V priority needs and performance measures. /2007/

/2008/ There were over 100 hits to the Title V public input section of the IDPH Web site. There were several e-mails from local community partners providing input on the state priorities, performance measures, and activities within the performance measures.

The Council endorsed the state plan at their June 14, 2007 meeting. The members were also asked to provide public comment via the IDPH Web site for the needs assessment and the state performance measures. The Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned about MCH issues. Local contract MCH agencies were encouraged to provide input on the Title V priorities and performance

measures. /2008/

/2009/ There were about 550 hits to the Title V public input section of the IDPH Web site. There were several emails from local community partners providing input on the state priorities, performance measures, and activities within the performance measures. This input was used to provide enhancement for the application.

The Council endorsed the state plan at their June 12, 2008 meeting. The members were also asked to provide public comment via the IDPH Web site for the needs assessment and the state performance measures. The Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned about MCH issues. Local contract MCH agencies were encouraged to provide input on the Title V priorities and performance measures. /2009/

/2010/ Members of the MCH Advisory Council were presented the priority needs and performance measures and were encouraged to provide public comment on the Title V public input section of the IDPH Web site. The Council endorsed the plan via electronic vote after their June 11 meeting. Local contract MCH agencies were also asked to provide public comment, and in all, there were about 150 hits to the Web site. Input was used to provide enhancement for the application. //2010//
An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

/2010/ The Iowa five-year needs assessment continues to serve as an accurate reflection of the established MCH priorities. However, in some need areas, data related issues suggest that the original indicators may no longer be an accurate reflection of progress. For selected need areas, further exploration is needed to identify or develop indicators that might serve as more reliable measures of progress. (See SPM for details.) Activities to address priority needs continue to rely on collaborative partnerships, which took on additional importance as the state's economy entered into a downturn.

Programs that rely on Title V funding as a core component of their budget were forced to reduce services. In FFY08, the carry forward funds from previous years' funding were fully expended, resulting in a series of budget reductions. Reductions to Title V supported staffing (within the Bureau of Family Health) as well as state level program contracts were implemented in FFY08 and continued in 2009. Community-level programs received similar reductions in March 2009. While all components of the system are affected, local MCH agencies were most dramatically impacted, laying off staff and cutting service delivery at the community level by approximately 15 percent. State resources for public health are strained as the state faces unprecedented budget challenges.

Components of the needs assessment are updated annually (See Needs Assessment attachment). Ongoing updates provide groundwork for the next cycle in the 5-year planning process and assist in identifying significant changes in the intervening years. In addition, the 2005 Iowa Child and Family Household Health Survey continues to serve as the foundation for population-based needs assessment for Iowa's MCH population and provides guidance for strategic planning and program development.

The fourth of five summary reports, "Physical Activity, Weight, and Eating Habits," was released in April 2008. The fifth and final summary report, "Racial and Ethnic Disparities in the Health and Well-Being of Iowa Children," was completed in April 2009.

Ongoing connection with contemporary public health issues has led CHSC to consider an emerging area of need related to concepts of "social determinants of health (SDOH)" and "health equity." SDOH such as wealth inequality, food insecurity, and housing instability are upstream causes of health disparities and poor outcomes - individually and communally. Health equity is the result of remedying health disparity. CHSC plans to investigate the role of SDOH in early childhood health risk, interventions, and outcomes; and then advocate for related policies and practices to promote early childhood health equity.

Selected indicators suggest progress during FFY08 in addressing priority needs. Objectives were met for five of the ten state's priority needs. Less than expected progress was achieved for the remaining five state priority needs. Review of accomplishments suggests that lack of success in reaching selected target values was primarily related to four factors: 1) Establishing ambitious objectives to motivate continuous performance improvement; 2) Underestimating the timeframe interval between when improvement strategies are implemented and the when results are reflected in the indicators selected for measurement; 3) Changes in data sources or data collection methodology issues; and

4) Lack of resources/available funding that was not anticipated when the annual objectives were established.

The state plan provides a framework for community health planning and for advancing state-level policy development. Local public health agencies and local MCH agencies are encouraged to utilize the state plan in developing local responses to needs identified. In 2008 and 2009, a plan summary was published and broadly distributed among stakeholders. The state plan, Iowa's Family Health Plan 2009 which includes the needs assessment and corresponding plan is posted on the Web at http://www.idph.state.ia.us/hpcdp/common/pdf/TitleVAnnual.pdf Key strategies for dissemination are presentations and work groups with a focus on the Bureau of Family Health Grantee Committee, which represents local MCH contract agencies, and the MCH Advisory Council. Both stakeholder groups are actively engaged in reviewing progress on objectives and developing the subsequent year's plan. Local agencies report their contributions to addressing state priorities as part of their annual continuation application. The primary purpose of MCH Advisory Council is to assist the department in the development of and planning for the MCH Title V Block grant.

The planning process for the FFY 2011 Five-Year Needs Assessment is in progress. The process is led by the core group of program managers and data specialists. A comprehensive process will seek to build on progress- to-date and also capture emerging issues. The prioritization process is designed to engage communities, families and advocates. //2010//

The SAMHSA System of Care project in northeast Iowa has completed its planning and, now, nearly 3/4ths of its first implementation year. This project is addressing our state priority need to improve access to pediatric specialty care - mental and behavioral health specialty care, in this case. A "wraparound" model of service delivery promotes the family-driven, youth-guided service philosophy. A prescribed evaluation plan will assure ability to determine the influence of the service delivery model on child and family outcomes. ***/2010/ The System of Care project continues to enroll children and youth with severe emotional disorder and to collect data to evaluate the effectiveness of this major system improvement project. //2010//***

The Iowa Medical Home Initiative (IMHI) and the Iowa/Nebraska Primary Care Association (IA/NEPCA) have partnered to investigate the potential contribution of the medical home model to selected health provider organizations considered to be part of Iowa's safety net - specifically rural health clinics, free medical clinics, MCH clinics, and local boards of health. IMHI staff provide technical assistance and resource sharing to interested safety net provider staff. The ultimate goal is to help meet the state legislative mandate that safety net providers "help families determine a medical home." ***/2010/ A new CHSC task force is systematizing the availability and quality of care coordination services available to primary care practices seeking to provide a medical home quality of care to its CSHCN patients. //2010//***

CHSC has expanded its Parent Consultant Network (PCN). There are now over 30 employed members of the PCN serving as peer-to-peer support and as care coordinators in several program areas. Programs in which PCN members serve include: 1) Medicaid Waiver programs; 2) Iowa's Part C early intervention program; 3) the SAMHSA System of Care project; 4) the Early Hearing Detection and Intervention project; and 5) the CHSC direct clinical service programs. Through these programs and projects, the PCN is allowing CHSC to progress toward meeting the priorities of greater family participation, greater family satisfaction, and improved organization of services.

III. State Overview

A. Overview

Key factors that provide context for the state's Maternal and Child Health (MCH) annual report and state plan are highlighted in this overview. This section briefly outlines Iowa's demography, population changes, economic indicators and significant public initiatives. Additionally, major strategic planning efforts affecting development of program activities are identified.

Iowa's Land

Most of Iowa is composed of gentle rolling prairies, covered with some of the world's most fertile soil and lies between the high bluffs of the Mississippi and Missouri Rivers. Iowa is one of the country's most important and prosperous agriculture states and is known as the breadbasket of the country. The deep black soil yields huge quantities of corn, soybeans, oats, hay, wheat, and barley, which help support its cattle and hogs and supplies the large food processing industry. Manufacturing, especially agribusiness, is a large source of income for Iowans.

Changes in Demography

Iowa is a rural state with approximately 2.9 million people. According to census projections, Iowa will experience a modest three percent growth in population by 2015. The population will continue to shift from rural areas to urban areas. One-third of Iowa's 99 counties are expected to lose population. Ninety-four percent of the population is white; however, racial and cultural diversity is increasing. Residents of Hispanic origin are the fastest growing ethnic group. ***/2010/The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.2 percent in the 2008 estimate. Birth data also indicate an increase in Hispanic population. In 2000, live births to Hispanic women made up 5.6 percent of all births, double the population proportion in the same year. This ratio continues in 2008 (8.2 percent vs. 4.2 percent). Approximately 240,041 children are ages 5 and under and make up about 8.0 percent of the total population. Of the children between the ages of 0 and 5, 8.9 percent are children of Hispanic origin and there are an estimated 8.9 percent of children who have a special health care need. Children ages 19 and under had a higher rate of poverty (22.3%) than the general population (16.5%) in 2007. //2010//***

Employment and Population Changes Iowa's unemployment rate has steadily increased since 2000. The 2000 unemployment rate was 2.6 percent and it has increased to 4.8 percent in 2004. /2009/ The 2007 unemployment rate has decreased to 3.8 percent. /2009/ ***/2010/ The 2008 unemployment rate has been increasing consistently from 3.9 in January to 4.4 in December. //2010//***

The most notable population change is the increase in Hispanic immigrants. Census estimates show that residents of Hispanic origin increased from 2.8 percent in 2000 to 3.5 percent in 2004. Iowa's overall population has increased by 1.4 percent from 2000 to 2005. /2009/ The most notable population change is the increase in Hispanic immigrants. /2009/ ***/2010/ Census estimates show that residents of Hispanic origin increased from 2.8 percent in 2000 to 4.2 percent in 2008. Iowa's overall population has increased by 2.6 percent from 2000 to 2008. /2010/***

/2010/ Even with the influx of new citizens, Iowa's total population is projected to experience only modest growth between now and 2015. While the overall population remains stable, the minority populations are expected to grow in both absolute numbers and total population. //2010//

Poverty

The percentage of families in Iowa living at or below the federal poverty level has been fluctuating. In 2000, the rate was 10 percent and in 2002 the rate decreased to seven percent. The 2004 data showed an increase in the number of families living in poverty to 9.2 percent. This

is approximately 68,000 families defined as poor by the federal poverty level. There were 12.8 percent of children 0-17 years old living at or below the federal poverty level in 2004. /2009/ The 2006 data showed an increase in the number of families living in poverty to 7.3 percent. This is approximately 58,000 families defined as poor by the federal poverty level. There were 13.7 percent of children 0-17 years old living at or below the federal poverty level in 2006. /2009/

/2010/ The 2008 data showed a decrease in the number of families living in poverty to from 7.3 percent in 2006 to 6.1 percent in 2008. This is approximately 50,000 families defined as poor by the federal poverty level. There were 13.3 percent families with children ages 0 to 17 living at or below the federal poverty level in 2007. //2010//

Community Empowerment Areas
Iowa has been progressive in implementing partnerships between local and state government. In 1997, legislation provided for the establishment of "innovation zones." Several state agencies collaborated with local organizations within approved zones to reduce barriers to services as identified by communities. In 1998, legislation was passed which built upon the "innovation zones" concept to promote "empowerment" areas. The purposes of Community Empowerment legislation were to establish local community collaborations, create a partnership between communities and state government, and improve the well-being of children 0-5 years of age and their families. An additional goal was to empower communities to build a system of services to improve the effectiveness of local education, health, and human services programs. Community Empowerment areas have been designated to cover all 99 counties. This legislation directly influences community-based MCH services in Iowa.

Iowa was one of five states and one community to receive a Technical Assistance Grant to help strengthen and expand the state's and local partnership for providing quality care and education for young children in Iowa. The Technical Assistance Grant was from North Carolina Smart Start National Technical Assistance Center. The grant started in January of 2002 and will continued through January 2004. The grant was for technical assistance funding up to $150,000 including: On-call coach, information and referral, site visits, mentoring program, conference calls, Smart Start Resource material, and Smart Start Speakers Bureau.

The following recommendations were designed to build upon and strengthen Community Empowerment's accomplishments and assist the initiative in moving to the next level of development:

1. Develop a comprehensive, compelling, and unifying vision for all of Iowa's young children.
2. Strengthen and build on the accountability for results at the state and local level.
3. Deepen and broaden the public will to support early childhood issues.
4. Strengthen the leadership to increase support for Community Empowerment and the greater vision for early childhood in Iowa.
5. Expand organizational capacity to meet the greater vision for young children.

Through the Smart Start Technical Assistance Grant a core early care, health, and education stakeholder group was formed. The purpose of the stakeholder group was to be an advisory group to the early care, health, and education system. The stakeholders include representatives from public and private entities throughout the state. The functions of the stakeholder group are to review, design, and participate in cross functional proposals, understand all parts of the system, create and update the plan, agree on common language for the system, develop a menu of best practices, encourage relationships across disciplines, and be a resource to the system.

The Bureau of Family Health in partnership with Community Empowerment developed an early childhood plan through the HRSA Early Childhood Comprehensive Systems grant. Key personnel from IDPH are the project director and coordinator. The State Empowerment Team has served as the coordinating body of the grant. The Early Childhood Iowa Stakeholders have served as the advisory body for the grant. Grant Initiatives have promoted the development of community-

based comprehensive systems of services that assure coordinated, family centered, and culturally competent care for children.

The Early Childhood Iowa Stakeholder group developed Iowa Early Care, Health, and Education Strategic Plan. The stakeholder members are responsible for taking the goals, indicators, and strategies back to their constituents to get buy in. The IDPH applied for a three-year implementation grant in May 2005. /2007/ IDPH applied for the second year implementation continuation grant in June 2006. /2007/

The Early Childhood Iowa Stakeholder members developed six component workgroups to help move the system planning forward. The six component workgroups are: 1. Quality Services and Programs; 2. Public Engagement; 3. Resources and Funding; 4. Results Accountability; 5. Governance and Planning; and 6. Professional Development. More information on the Early Care, Health, and Education System building activities can be found at www.earlychildhoodiowa.org

/2007/ Community Empowerment launched a new parent Web site for families with young children. (www.parents.earlychildhoodiowa.org). The Web site will serve as a hub for the many online resources available to parents with young children.
This Web site provides information on the following categories: parenting, health and safety, child development, child care, preschool, healthy teeth, healthy eating and physical activity, community resources, 2-1-1 information and referral, learning to read and write, pregnancy, financial help, and help me now.

In addition to clicking on the categories, there is an A-Z search that will search for resources within the Web site. There is an evaluation component on the Web site to encourage general feedback and suggestions regarding the information available through the Web site. The Web site will be updated on an on-going basis to incorporate feedback. /2007/

/2008/ IDPH applied for the third year implementation continuation grant in June 2007. Iowa has developed a single, comprehensive plan for the Early Care, Health, and Education system. More information on the Early Childhood Iowa system building activities can be found atwww.earlychildhoodiowa.org. /2008/

/2009/ IDPH applied for continuation funding to continue the work on the integration of a comprehensive early childhood system through MCHB. In the 2008 General Assembly, Early Childhood Iowa was formalized in legislative language. The language provides a formal structure for the Council and the State Agency Liaison Team. The language also names the Iowa Department of Public Health as the lead agency for Early Childhood Iowa. /2009/

/2010/ IDPH continues to serves as the lead agency for Early Childhood Iowa (ECI) with financial support from the MCHB Early Childhood Comprehensive System project. ECI has been working on finalizing the rules for the past year and included input from the ECI Council members, component group members, local Community Empowerment stakeholders and the Board of Health. The rules were adopted and filed on July 9, 2009 at the Board of Health.

Current economic conditions pushed recent legislative sessions to more thoroughly and intentionally look at efficiencies and accountability in state government. Community Empowerment often became a focal point in conversations during legislative discussions. These discussions led to questions regarding the efficiencies and effectiveness of Community Empowerment, both at a state and local level. The Iowa Department of Management proposed to members of the legislature to host a Design Lean Event for Community Empowerment. Lean is a collection of principles, methods and tools that improve the speed and efficiency of any process. The Lean Event allowed for the opportunity to reflect and build on what works in Iowa while developing new models and

strategies based on the latest early childhood research. A diverse representation of state and local early childhood stakeholders came together for a week long process to identify first steps in improving the effectiveness and efficiency of the Early Childhood system. Four priority areas were identified and action plans have been developed. Over the next few months priorities and action plans will be shared with stakeholders. Priorities include: Levels of Excellence; Regionalization and Re-define Empowerment Areas; State Structure and Marketing.

Over the past two years, cultural competency has been a priority for ECI as demonstrated through hosting of the diversity symposium and retreat. As a result of these initiatives, a work plan was drafted. The work plan includes key strategies such as blending Early Care and Education settings; providing ongoing, focused, evidence-based professional development in multiple culturally-sensitive areas; monitoring child outcomes to identify gaps early; emphasizing high-quality, developmentally-appropriate practices; supporting teachers with translator services; and training parents to be advocates for their children. During the first year of this project period, the Governance component group will convene a diversity taskforce. The diversity taskforce will help finalize the work plan and provide leadership on implementing the strategies in the upcoming project period. //2010//

Legislative Session for Early Childhood
The legislative session ended on Friday, May 20th, 2005. Early Childhood Education was a priority during this legislative session.
Preliminary results indicate an additional spending of over $21.1 million for early childhood education. The preliminary numbers show additional spending of $10.4 million for Community Empowerment and an additional $10.75 million for child care. Below are a few of the highlights for the additional dollars:
Implement a quality rating system; Raise reimbursement rates for child care providers to the 2002 Market Rate Survey (effective September 1, 2005); Raise the child care subsidy eligibility for families from 140 percent to 145 percent of the Federal Poverty Level (effective September 1, 2005); and Raise the child care subsidy eligibility for families of children with special needs to 200 percent of the Federal Poverty Level.
Some of the specifics affecting Community Empowerment Areas include: $4.65 million of the State General Funds are targeted to support low income preschool tuition; and $1 million will support professional development activities between the Iowa Empowerment Board, community colleges and the area education agencies.
/2007/ 2006 Legislative Session for Early Childhood In May of 2006, Legislators appropriated $19 million to the early care, health, and education
system. The following information highlights the increases in funding: • $5,000,000 to be used by Community Empowerment Area boards for family support services and parent education programs targeted to families expecting a child or with newborn and infant children through age three. • $5,500,000 to assist low-income parents with preschool tuition expenses. Funds are to be used for children ages four and five who are not attending kindergarten; they are also to be used to serve families to not more than 200 percent of the federal poverty level. In addition, if funding is available after addressing the needs of those who meet the basic income eligibility requirement, a Community Empowerment Area board may provide for eligibility for those with a family income in excess of the basic income eligibility requirement through use of a sliding scale or other copayment provision. • $3,500,000 to be allocated for efforts to improve the quality of Early Care, Health, and Education programs. The IEB may reserve $100,000 for the technical assistance in the Iowa Empowerment Office State Technical Assistance Team. • $1,000,000 to be utilized by the IEB to implement the recommendations of the Business Community Investment Advisory Council. • $1,200,000 for Professional Development activities for providers working in Early Care, Health, and Education. • $150,000 for Access to Baby and Child Dentistry (ABCD) for local MCH agencies to build infrastructure for oral health issues. • $325,000 for Healthy Mental Development Initiative for children 0 to 5 years and their families. • $2,000,000 for child care provider rate reimbursement, rate annualization, and increase to 2004 rate. • $325,000 for support to the Child Care Quality Rating System. /2007/

/2008/ Legislative Session for Early Childhood -The 2007 Legislative session was complete the end of April. The following information provides an overview of the program and services funded for the Early Care, Health, and Education system.
Quality Affordable Early Care and Education Services
Timely Payments for Child Care Providers: establishes billing and payment standards for child care provided under the state child care assistance program administered by the Department of Human Services (DHS). Providers will be paid within 10 business days of submitting a correct invoice to DHS.
Early Head Start Projects: implements early head start pilot projects addressing the comprehensive cognitive, social, emotional, and developmental needs of children from birth to age three, including prenatal support for qualified families. The investment of $400,000 is the first time the legislature has appropriated state dollars to this federally funded program.

• Child Care Subsidy: provides $16 million for the child care subsidy program. This should keep DHS from having to start a waiting list for child care assistance.

High Quality Preschool Programs
Preschool Program for four year olds: creates a statewide voluntary preschool program for fouryear-olds. Provides 15 million each year over the next five years.

• Shared Vision --Preschool Project: provides a $1.7 million dollar increase to Shared Visions state funded preschool program.

Child Health Care Coverage

• SCHIP --Iowa's hawk-i program: provides language around SCHIP: "if federal reauthorization of the state children's health insurance program provides sufficient federal allocations to the state and authorization to cover the following populations as an option under the state children's health insurance program, the department may expand coverage under the state children's health insurance program as follows: a. By eliminating the categorical exclusion of state employees from receiving state children's health insurance program benefits. b. By providing coverage for legal immigrant children and pregnant women not eligible under current federal guidelines. c. By covering children up to age twenty-one, or up to age twenty-three if the child is attending school."
Healthy Child Development 1st Five --Healthy Mental Development: allocates $525,000 to 1st Five to increase partnerships with community health providers to improve developmental screening for young children (0-5 years).
Dental Screening: requires children to have a dental screening as a condition of enrollment in elementary or high school.

• Lead Screening: requires that children receive a blood lead test by age six or prior to enrollment in elementary school. A parent or guardian of a child under age two is strongly encouraged to have the child tested for elevated blood lead levels by age two.

Early Intervention
Early ACCESS: expanse the federal Individuals With Disabilities Education Improvement Act of 2004, as amended to January 1, 2007, birth through age three services due to increased numbers of children qualifying for those services. The allocation is $1,721,400.

• Early Hearing Detection: Allocates $238,500 that shall be used to provide audiological services and hearing aids for children.

Tobacco Tax
• Tobacco Tax: provides for an increase of $1.00 on cigarettes and tobacco products, creating a health care task force and providing for a standing appropriation.

Income Tax Treatment of Families with Children
Income Tax Credit: raises the state earned income tax credit from 6.5 percent to 7.0 percent and makes it refundable. This will benefit over 163,000 low-income working Iowa families. /2008/

/2009/ Legislative Session for Early Childhood -The 2008 Legislative session was complete the end of April. The following information provides an overview of the program and services funded for the Early Care, Health, and Education system.

Education Appropriations Bill
Provides $15,000,000 for the Four-Year-Old Preschool Program through the Department of Education; Instructs Empowerment to study and report to the General Assembly on Family Friend and Neighbor Care; Reduces the percentage of carry forward dollars for Empowerment Areas from 30% to 20%; effective with FY 2009 ending balances;
Instructs Empowerment to develop and implement a plan to strengthen fiscal accountability for CEA boards; Empowerment shall consider if support services to prevent the spread of infections diseases, prevent child injuries, develop health emergency protocols help with medication, and care for children with special health needs are being provided to child care facilities registered or licensed under chapter 237A; and $400,000 for the state Early Head Start programs.

Health and Human Services Appropriations Bill
Two percent increase for child care providers beginning October 1, 2008;
Increase in funding for Income Maintenance Workers; Funding of $18.4 million to avoid child care assistance waiting list; Requires child care homes and child development home to be located in a single-family residence; States if a child care record check is performed and the record indicates that the person has committed a transgression, the Department is required to perform an evaluation -even if the record check is withdrawn by the individual; and Codifies Early Childhood Iowa (ECI).

Child Care Studies
$30,000 to DHS for a child care study through a workgroup. The State Child Care Advisory Council shall serve as this workgroup to address implementation issues associated with a change in child care regulation to mandatory registration or voluntary or mandatory licensure. They shall also address professional development, ensuring articulation between programs, meeting the needs of both children and their parents, and enhancing community engagement. They shall cooperate with other early childhood stakeholders and the private sector. The workgroup is also charged to explore other issues, such as: Using the Internet to provide information to providers; Creating a database; Educating the public on the advantages of using a registered child care provider; and Requiring a state and federal fingerprint criminal history check.

$50,000 for a study of ways to enhance access to health insurance by registered child development home providers. This study shall be conducted jointly with the collective bargaining organization representing registered providers. This organization shall provide matching funds.

Health and Human Services Appropriations Bill
Funding for dental homes for children; Funding for mental health system for children;
Funding for hawk-i and hawk-i expansion; and Funding for a post-natal tissue and fluid banking network.

Smoke-Free Air Act: Prohibits smoking in public places, places of employment, and some outdoor spaces.
Child & Family Economic Success: Earned Income Tax Credit and Volunteer or Free Income Tax Assistance Programs: Requires the Iowa Department of Human Services to ensure that education materials relating to the federal/state EITC and locations of free income tax assistance programs are provided to households receiving assistance or benefits under: hawk-i, FIP, Medicaid, Food Assistance, and any other appropriate program. This information shall be provided through mailings or the Internet.

The dental home mandate language was amended this year. Original legislation indicated dental screenings and preventive care as necessary services within the dental home. The new language includes diagnostic services, treatment services, and emergency services. Also, the deadline was extended to December 31, 2010. Oral Health Bureau staff continues working closely with the Department of Human Services in development of the I-Smile program in order to meet the mandate. The legislature appropriated additional funding to DHS for SFY2009 to assist Title V child health contractors in implementation of I-Smile activities.
Administrative rules were written regarding codification of the Oral Health Bureau and mandatory oral screenings prior to elementary and high school enrollment. The original legislation for school screenings was changed slightly during this legislative session, eliminating provisional enrollment. The administrative rules will be in effect July 1. /2009/
/2010/ Due to the economic situation and lack of revenues the 2009 legislative session legislators had to make tough decisions about funding and program cuts. During the middle of the FY09, an across the board 1.5 percent budget reduction was implemented. This displayed the need for additional cuts in the 2010 budget. An overall budget cut for local Community Empowerment areas was 12 percent of the state funds. The First Year First public and private partnership funding was also decreased from two million to $250,000. Request for Proposals for local matching grants will continue but on a much smaller bases. //2010//

Public Health Redesign
/2007/Redesigning Public Health in Iowa is a partnership between local and state public health. Dozens of local and state public health professionals have been directly involved in shaping the future of Iowa's public health system. These individuals have served on committees to help guide the redesign initiative and to develop public health standards.

The Work Group for Redesigning Public Health in Iowa serves as the steering committee for the initiative. The Work Group sets the direction, develops goals, and oversees activities for the initiative. The Iowa Department of Public Health (IDPH) provides a facilitator/coordinator for the Work Group.

The Work Group established two sets of Standards Committees to draft public health standards for the state of Iowa. The local standards committees developed standards and criteria in 2005-06 that pertain to local public health. The second set of committees added state criteria to the local standards in 2006-07. The resulting document is the draft of the Iowa Public Health Standards, April 2007.

Both sets of committees were structured around the components of the standards as follows:
1. Governance, Administration
2. Workforce
3. Communication and Information Technology
4. Community Assessment and Planning, Evaluation
5. Prevent Epidemics and the Spread of Disease
6. Protect Against Environmental Hazards
7. Prevent Injuries
8. Promote Healthy Behaviors
9. Prepare for, Respond to, and Recover from Public Health Emergencies /2007/

/2008/ The Work Group for Redesigning Public Health in Iowa released a draft of the Iowa Public Health Standards in April 2007. The new document combines the previous draft of local public health standards with state-level responsibilities. Committees comprised of local and state public health professionals and partners drafted the state criteria for the standards. After reviewing public comments, the Work Group anticipates releasing the next version of the Iowa Public Health Standards in Fall 2007.
IDPH is conducting a survey to assess local public health's capacity to meet the requirements of the local criteria of the standards. The results of the survey will be available by August 2007.

IDPH is planning to fund demonstration projects for local public health agencies to develop and implement strategies for complying with the standards.
Next steps for Redesigning Public Health include:
1. Conducting a survey to assess the capacity of IDPH to meet the state criteria of the standards.
2. Seeking additional resources and funding (federal, state, and private) to support the initiative.
3. Preparing a legislative package that includes desired code changes identified through developing the standards.
4. Monitoring national movement for accreditation.
5. Exploring an accreditation system for Iowa. /2008/

/2009/ In November 2007, the work group for Redesigning Public Health in Iowa held a strategic planning meeting to determine the next steps for Redesign. Five implementation committees were formed to oversee goal completion.
Those groups include:
1. A funding committee to look at the availability of funding currently for public health, the flexibility of funding, and forecasting future needs for funding.
2. A metrics committee to address how local agencies will measure their compliance with the criterion.
3. An increase knowledge committee that will form a communication plan and frame messages around the importance of public health and the need for implementation of the standards.
4. An accreditation committee to design an Iowa accreditation process, and make sure that it aligns with the national accreditation process currently being designed by the Public Health Accreditation Board (PHAB).
5. A code committee to assure that code and administrative code are inclusive of the Iowa Public Health Standards.

Other highlights:
• The Iowa Public Health Standards were finalized in December 2007.
• Three counties received funding from IDPH to conduct demonstration projects piloting component areas of the standards.
• Iowa was named one of 16 "Lead States in Accreditation" and will receive funding from Robert Wood Johnson Foundation for involvement in the Multi-State Learning Collaborative through 2011.
• IDPH received $25,000 from HHS to assist in the completion of a state assessment that looks at the ability of IDPH to meet the state criteria of the Iowa Public Health Standards. /2009/

/2010/ In January of 2009 IDPH hosted a team of site visitors from across the county to review the evidence gathered by the department in order to evaluate how well the department meets the state criteria of the Iowa Public Health Standards. The results of that report show the department meeting 76.1 percent of the state criteria. The site visit team made several recommendations about the process and priorities IDPH should consider to be aligned with the national movement towards accreditation.

The Public Health Modernization Act was signed by the governor in May of 2009. This act calls for the formation of a Public Health Advisory Council and Public Health Evaluation Committee to lead the way in formalizing the Iowa Public Health Standards and establishing a voluntary accreditation system for Iowa's local and state public health departments. This legislation is a product of several years of collaborative work between local and state public health partners.

The work of the five implementation committees established in 2008 came to a close on June 17, 2009. The committees completed several products in the areas of accreditation, code, funding, increase knowledge, and metrics. Those products and recommendations from each committee will be passed onto the Public Health Advisory Council and Public Health Evaluation Committee when they begin meeting in the fall of 2009. //2010//

Newborn Hearing Screening Program

For the past several years, IDPH has taken a leadership role in establishing a quality system for Early Hearing Detection and Intervention (EHDI) in Iowa. In January 2004, Iowa implemented EHDI legislation that mandates every newborn be screened for hearing loss prior to hospital discharge and that the screening results be reported to IDPH within six days of the child's birth. The legislation also requires that the results of any rescreens and diagnostic assessments be reported to IDPH for any child under three years of age.

On April 1, 2005, the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources and Service Administration (HRSA) awarded an Early Hearing Detection and Intervention grant to the state of Iowa. This grant was awarded to Child Health Specialty Clinics (CHSC).

The activities of this grant focus on reducing the number of infants who are "lost" in the system, therefore delaying the provision of early intervention services. The five goals identified in this grant are:

· All newborns will be screened appropriately prior to hospital discharge.
· All audiologic diagnoses will occur before children are three months of age.
· All eligible children will be enrolled in an early intervention program (Part C, Early ACCESS) before six months of age.
· All families with children 0-3 who are deaf or hard-of-hearing or are at risk for late-onset hearing loss will be linked to a medical home.
· All families with children 0-3 who are deaf or hard-of-hearing will receive family-to-family support.

IDPH recently entered into a three-year cooperative agreement with the Centers for Disease Control and Prevention. The activities of this agreement focus on developing and implementing a statewide EHDI surveillance system. The goals of the project are to:

· Complete the statewide implementation of the EHDI data system.
· Facilitate data integration linkages with related screening, tracking, and surveillance programs.
· Maximize the use of EHDI data for statewide and local decision making.
· Evaluate the Iowa EHDI system based on the performance indicators set forth in the National EHDI Goals and utilize the results to establish project sustainability.

Perinatal Guidelines

The 1998 Legislature directed IDPH to develop and maintain statewide perinatal guidelines. State guidelines were available previously; however, the new administrative rules were written with input from the public and the Perinatal Advisory Committee. These rules, effective March 17, 1999, allowed for voluntary participation by the hospitals. The guidelines provide the framework to be used in defining and evaluating the level of perinatal services being offered. It also outlines the steps and process for a hospital to be reviewed for a new designation. Facilities that provide hospital care for obstetrics and newborn infants are classified on the basis of functional capacities and organized within a regionalized system of perinatal care. This regionalized system of perinatal care helps ensure that each newborn infant is delivered and cared for in a facility appropriate for his or her health care needs and to facilitate the achievement of optimal outcomes. The functional capabilities of facilities that provide inpatient care for obstetrics are classified from basic to comprehensive services.

/2007/ IDPH and the Perinatal Advisory Committee are in the process of updating the Perinatal Guidelines. The Committee is hoping to have the final guidelines by December 2006. /2007/

/2008/ IDPH and the Perinatal Advisory Committee are still in the process of updating the Perinatal Guidelines. The committee recommended adding a level of neonatal care, which delayed the release, and to amend the rules regarding the levels of perinatal care in the Iowa Administrative Code. This year there were also changes in legislation regarding HIV testing of pregnant women. The guidelines are being updated to including these changes. The 8th edition of the guidelines should be completed and released to the public by the fall of 2007. /2008/

/2008/ March of Dimes Funds Pregnancy Risk Assessment Monitoring System Pilot Project
The Iowa State Chapter of the March of Dimes awarded nearly $10,000 to the Iowa Department of Public Health for its Iowa Pregnancy Risk Assessment Monitoring System pilot project (I-PRAMS)./2008/

Currently, the Department sponsors a survey of new moms before they leave the hospital to find out about their behaviors and experiences (e.g., nutrition, stress, weight, smoking, etc.) before and during pregnancy as well as their baby care plans once they return home (e.g. sleep position, breastfeeding, etc.). I-PRAMS will take this one step further through a follow-up phone survey with new moms four months after delivery. We will learn if moms were able to follow through with their plans and if not, why not. In addition, I-PRAMS will provide information about moms' well being after pregnancy and the families' access to newborn/well baby care. Survey participants will be randomly selected among all new moms in Iowa. /2008/ /2009/ Over 400 randomly selected new Iowa moms completed surveys in calendar year 2007. We expect to have preliminary data results based on calendar year responses by late July 2008. /2009/ ***/2010/ The calendar year 2008 I-PRAMS pilot project data collection and entry has been completed and we are in the process of analyses. The total survey sample size was 1,800 and we achieved an overall response of 1,233 (68.4%). //2010//***

State Child Health Insurance Program
In response to the federal initiative of State Children's Health Insurance Programs (SCHIP), the 1998 Iowa Acts, Chapter 1196, authorized health care coverage for specified uninsured children in Iowa. Legislation created a plan that expanded Medicaid eligibility to children whose family incomes were up to 133 percent of the federal poverty level. Iowa also chose to establish a separate private insurance plan for children with a family income between 133 percent and 200 percent of the poverty level; this program is called hawk-i (Healthy and Well Kids in Iowa.)

In July 1999, the Family Health Bureau became a Robert Wood Johnson Foundation (RWJF) grantee for Iowa's Covering Kids project. The projects focused on three goals 1) design and conduct outreach programs in pilot communities to help identify and enroll children into Medicaid or hawk-i; 2) simplify the enrollment and renewal process and 3) coordinate existing coverage programs for low-income families. The Covering Kids grant ended in 2002. However, RWJF extended the grant entitled Covering Kids and Families (CKF) that builds on Covering Kids efforts. On July 1, 2005, Iowa's CKF began the fourth year of the project. Priorities for year four were to 1) engage school districts to accept a central role in assuring health care coverage for children; 2) develop suggested guidelines and materials to support the role of health care professionals in providing consumer education on health care coverage; 3) identify and analyze barriers to enrollment and renewal and make comprehensive policy and program recommendations for removing barriers; and 4) assure coordination of state level and community based enrollment efforts.

In addition to the CKF project, the Bureau of Family Health became the contractor with DHS for providing state level hawk-i outreach in 2002. A full-time state hawk-i outreach coordinator provides outreach coverage for state level initiatives and the local child health agencies provide outreach coverage for all 99 counties at a local level. The local coordinators focus outreach on faith based organizations, schools, health care providers and special populations while working with key stakeholders on outreach initiatives.

/2007/ The CKF project will end June 30, 2006, with a request to extend the project until September 30, 2006. CKF sustainability efforts will focus on building activities and strategies that support enrollment into SCHIP into the Title V and hawk-i outreach infrastructure. The process improvement collaborative team developed through CKF will continue to look at maximizing the efficiency and effectiveness of Medicaid and hawk-i eligibility systems through addressing barriers to enrollment and retention. Barriers to enrollment and retention will be identified through use of a study conducted by the University of Iowa Public Policy Center and through the expertise

provided by the CKF pilot sites. Strategies to reduce barriers will be small scale tested for effectiveness and implemented statewide when proven effective. hawk-i outreach efforts will continue through each local Title V agency with coordinated leadership provided by IDPH through the Outreach Task Force. Training will be provided to outreach coordinators through the Outreach Task Force and two statewide conferences. The CKF state coalition will continue to look at funding sources for sustainability of identified key activities that work to reduce barriers to enrollment and increase public awareness of Medicaid and hawk-i. /2007/

/2008/Sustained funding for Covering Kids and Families in Iowa continued through support provided by the Wellmark Foundation. In addition, a special project titled Iowa Covering Kids and Families: Access through Health Literacy began in May 2006 and was completed in April 2007. The project seeks to reduce the number of uninsured Iowa children through improved health literacy. Principles of health literacy were applied to reduce enrollment barriers in health care coverage programs and increase health literacy awareness. Building on experience and resources developed through the seven-year CKF project, this initiative worked through a statewide coalition and a trained process improvement team to achieve project goals. Through a structured change process, the project addressed two main goals: 1) apply principles of health literacy to selected materials and develop additional resources for families and key stakeholders; 2) provide health literacy training for key stakeholders. To achieve these goals, the coalition restructured to combine workgroups and focused on outreach, simplification and coordination of health care coverage for Iowa children. In addition, the coalition continues to develop policy briefs to educate and inform key decision makers on health care coverage issues affecting Iowa children. Statewide outreach for hawk-i continued to took place through schools, faith based organizations, health care providers and special populations. Coordination of outreach took place through sustaining an Outreach Task Force which brings together hawk-i outreach coordinators across the state to discuss barriers to enrollment and retention of children in public coverage programs. /2008/

/2009/ The Healthcare Reform" legislation. The intent of this legislation is to provide all children with hawk-i and Medicaid insurance coverage by January 1, 2011 and to expands the hawk-i program up to 300 percent FPL if federal funding becomes available. If federal funding does not become available, state only money will be used to create a program that builds upon the current hawk-i program. It establishes an electronic health information commission, end of life care promotion, extends coverage for children through age 25 who are on their parent's health insurance plan, eases restrictions on preexisting conditions, establishes a medical home initiative, wellness, chronic care, transparency and direct care worker provisions. /2009/

/2010/ For the second year in a row, Iowa's legislature passed landmark, comprehensive health care reform. SF 389, Health Reform Bill, takes up several of the options from the federal CHIP legislation and significantly improves health care coverage and access for Iowa's children and families. The legislation deems hawk-i creditable coverage; allows for the use of one pay stub as verification of income for Medicaid and hawk-i; allows for the averaging of three years of income for self-employed persons to establish eligibility for Medicaid and hawk-i; directs the state to complete the following for Medicaid and hawk-i : utilize joint applications and the same application and renewal processes, implement administrative or paperless verification at renewal, utilize presumptive eligibility when determining a child's eligibility, and utilize the express lane option to reach and enroll children; and creates a dental-only option in hawk-i for children who have medical but not dental coverage.

Emerging from last year's health reform legislation, effective July 1, 2009 eligibility for hawk-i was expanded to 300% FPL and for Medicaid for pregnant women and infants less than one year of age to 300% FPL. As part of SF 389, also effective July 1, 2009, children in lawful permanent resident status may receive Medicaid or hawk-i coverage if they are otherwise eligible, regardless of their date of entry into the United States; thus eliminating the past five-year bar placed on this population. Due to expanded eligibility, the

Department of Human Services in cooperation with the Department of Public Health and other appropriate agencies, will apply for grants available under CHIPRA to promote outreach and quality child health outcomes under the Medicaid and hawk-i programs. //2010//

Health Reform

/2010/ As a result of the national and state level attention to health care, Iowa enacted a Health Care Reform bill (HF 2539) during the 2008 Iowa General Assembly's 2008. A Medical Home System Advisory Council was established from this legislation. The council's charter is to advise and assist the Iowa Department of Public Health in implementing a medical home system for Iowa. The Health Care Reform bill provides a blueprint for the future of Iowa's medical home system. The blueprint defines medical home, outlines needs for the statewide structure, and focuses on the joint principles of a patient centered medical home. The Health Care Reform bill also identifies phases for medical home beginning with children enrolled in Medicaid. The proposed outcomes for the medical home system are to reduce disparities in health care access, delivery and health care outcomes; improve the quality and lower the costs of health care; and provide a tangible method to document whether or not each Iowan has access to health care. Health improvement goals and outcomes will be developed for children, including children with special health care needs. For children, goals and performance measures will include childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization and oral health service utilization. The medical home system for children will coordinate and integrate with existing newborn and child health programs and entities including local maternal and child health agencies, Community Empowerment and Early Childhood Iowa. //2010//

Fit for Life

The IDPH has awarded CDC funding to address nutrition and physical activity to prevent obesity and other chronic diseases. The funding is intended to build the state's capacity to address the epidemic of overweight and obesity. Currently the focus is building partnerships to write a comprehensive state plan for nutrition and physical activity. The Iowans Fit for Life Partnership will assist with writing the six components of the state plan: educational settings, early childhood, older Iowans, business and agriculture, health care, and community. More information can be found at: http://www.state.ia.us/iowansfitforlife/

/2007/ The plan will be completed and the Iowans Fit for Life Partnership will begin implementing individual objectives and strategies. The intervention will continue in the 12 communities. /2007/

/2008/ The Iowans Fit for Life Partnership continues to implement objectives and strategies. The intervention continues in the 12 schools and communities. /2008/

/2009/ The Health Promotion and Wellness Unit of the Bureau of Nutrition and Health Promotion is inclusive of Fit for Life. An Iowa Healthy Communities Initiative Grant Program has been implemented using continuation funding for the Harkin Wellness Grants and state appropriations. This grant initiative integrates several programs across the department and will provide wellness grants to communities for measurable health improvements. These two year grants offer local boards of health working with local partnerships the opportunity to plan and implement local health programs to address community needs. Focus areas include nutrition, physical activity, tobacco use prevention, mental health, oral health, and prevention of chronic disease. The applications are due in July of 2008 and the grant period will run through July of 2010. /2009/

/2010/ Iowans Fit for Life continues to develop nutrition and physical activity resources for Iowans in the areas of worksite wellness, healthcare settings, the community and schools. The four year pilot intervention in 12 communities and schools concluded in May of 2009. Iowans Fit for Life continues to collaborate within the Bureau of Nutrition and Health Promotion on the Iowa Healthy Communities Initiative Grant Program providing technical

assistance to grant recipients. //2010//

Building Healthy Communities in Iowa through Harkin Wellness Grants
On May 23, 2005, IDPH issued an RFP to local Iowa communities for 36 Building Healthy Communities in Iowa through Harkin Wellness Grants. Examples of eligible community organizations are counties, cities, schools, tribes, health departments, and philanthropic organizations. The goals of the grants are planning and promoting individual and community health and wellness, prevent the incidence of chronic disease, and sustain these efforts into the future. ***/2010/ IDPH issued two requests for proposals to Local Boards of Health for the Iowa Healthy Communities Initiative during the summer and fall of 2008. Twenty-four projects were funded through a blend of state and federal funds.***

The RFP explained that building healthy communities in Iowa will not happen by accident or through a single program, but through a comprehensive, community-based approach. Five components of a process to build healthy communities include:
1. Strengthening the grassroots effort to address the communities' health and quality of life issues,
2. Embracing a process that will determine a measure of where the community is (assessment) and where it should go (vision),
3. Maintaining the commitment of key partners by engaging them in specific strategies that can move the community toward the vision,
4. Promoting structural and systematic change that will result in health and quality of life improvements, and
5. Maximizing limited resources and leveraging additional resources including possible redirection of resources to areas that help the community achieve the vision.

The Iowa Healthy Communities Initiative Community Wellness Grant model builds on the highly successful 2006-2007 Harkin Wellness Grant program. The model includes four main components:
1) Local Boards of Health as the grant applicants,
2) Community coalitions with local public health as an active, engaged partner,
3) Technical assistance provided by the health promotion unit in IDPH, with consultation from the IDPH Office for Healthy Communities, and
4) Evaluation of the community project and the technical assistance provided to the community.

Of the twenty-four 2008-2009 Community Grants, four include a mental health focus, two include tobacco prevention, one an oral health component, and the remaining projects are in the areas of nutrition, physical activity or chronic disease prevention. Two counties include an early childhood component. Several projects are directed toward school-aged youth and include programs such as CATCH™ (Coordinated Approach to Child Health), SWITCH™ (a program that includes limiting screen time from the National Institute on Media and the Family), and Pick a better snack™ & ACT. One project is providing cooking classes to community members. Another project provides school-aged youth and their families a family meal with information on preparation, as well as incorporating nutrition and physical activity around literacy and math skills. Evaluation outcomes of the projects will be reported the fall of 2010.

The communities that were approved for the 2006-2007 Harkin Wellness Grants included local public health agencies (9 awards), cities (4), hospitals (4), worksites (4), Iowa State Extension Offices (3) and a series of other entities such as schools, foundations, YMCA organizations and a mental health center. Of these awardees 26 of the 28 are doing some component of nutrition and physical activity programming. Ten of the 28 are doing tobacco abatement programs and seven of the 28 have a mental health component as part of their work plan.

Twenty-eight grant awards were made and over the 2005-2007 grant period the funded communities accomplished the program goals in a variety of ways. George, Iowa used volunteer hours to build a trail completely surrounding their community and developed walking programs and support groups to improve health status. Aurora, Iowa developed a wellness center that has had constant use since it opened its doors. An Iowa school system created a playground that encourages physical play, minimizes injuries and in conjunction with changes in school policies that allow recess times for play has made a large impact in the health, and well being as well as the attitudes of the children. Another community created a nutrition education, tasting opportunities, and an after school activity program in two of its elementary schools. They partnered with their city YMCA and Parks and Recreation Department to engage the community in the health of their children. This partnership has spawned multiple other active children partnerships and is now being sustained within city budgets. A worksite wellness program developed in one project community created a valued series of health programs, screenings and even healthy cooking classes for employees. The employers have reported enough health benefit to request the project to continue the services in a fee-based arrangement. Success here shows up in health care costs as a result of healthier employees who are better able to self manage their own chronic illness or develop healthier lifestyles to prevent disease.

The Health Promotion unit at IDPH is anticipating the release of a new RFP for a third round of Community Wellness Grants. The Iowa Community Grant Model will continue. The technical assistance provided by the Health Promotion team will be enhanced through additional training and monitoring. Training for the Health Promotion staff will be supported by the Office for Healthy Communities. The Office for Healthy Communities (OHC) works to foster healthy communities through education, consultation and resources to improve and strengthen community health. Healthy communities produce stronger economies, better education outcomes, safer environments and a healthier people. The Office for Healthy Communities provides technical assistance and support services to help communities improve their capacity to plan and implement health improvements. The Office also acts as liaison to IDPH for the NE Iowa Kellogg project called Food and Fitness and the Built Communities projects of Economic Development as well as the AARP projects known as Livable Communities. //2010//

Children with Special Health Care Needs

Child Health Specialty Clinics (CHSC) is Iowa's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN). The CHSC administrative office is located at the University of Iowa in Iowa City. Including the Iowa City office, CHSC currently supports 13 regional centers throughout the state. ***/2010/ There are now 14 CHSC regional centers, three of which are primarily dedicated to building an improved family-driven, youth-guided system of care for children's mental health services under a cooperative agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA). //2010//*** Regional centers provide and manage a number of services for CYSHCN, including direct care clinics, care coordination, family support, and infrastructure building services, including core public health functions (assessment, policy development, and assurance), training, program evaluation, and quality improvement. Additionally, the CHSC Director, Jeffrey Lobas, M.D., works collaboratively with the state MCH Director, Part C (of IDEA) Coordinator, and Medicaid Director to implement and develop programs to meet the health-related needs of all Iowa children. The collaboration is enhanced by Dr. Lobas's 0.2 FTE appointment as Medical Director for the Division for Health Promotion and Chronic Disease Prevention of IDPH. /2009/ Dr. Lobas resigned as CHSC's director in December, 2007. Brian Wilkes, MSW, is CHSC's new Chief Administrative Officer and co-director. A new CHSC Chief Medical Officer (CMO) and co-director has been recruited and is expected to join the program in late ffy'08. The new CMO is expected to be 0.4 FTE with CHSC and additional FTE commitments to the Bureau of Family Health and the University of Iowa Dept. of Pediatrics will be determined. /2009/ ***/2010/ A new CHSC CMO and overall program director was hired in September, 2008. Debra Waldron, MD, MPH, is a board certified pediatrician with additional extensive public health experience in system***

development and quality improvement. Dr. Waldron also serves as the medical director for the IA Dept. of Public Health Division of Health Promotion and Chronic Disease Prevention. //2010//

Organizational capacity has varied over the previous five-year program cycle. The Title V MCH Block Grant reformulation, state de-appropriations, and then re-appropriations, have demanded annual "scenario planning" activities by program leadership. As a result, both hours of operation and array of service offerings have fluctuated. When services such as cardiology, gastroenterology; and community-based nutrition consultation for CYSHCN have been decreased or eliminated, CHSC works to assure that resulting service gaps are minimized. When new grants or contracts are obtained, consideration is given to the sustainability of new initiatives or services. ***/2010/ Significant state budget reductions are requiring equally significant CHSC program redesign with the underlying intention of maintaining as high a quality as possible of CSHCN services delivered as efficiently as possible across all MCH pyramid levels. CHSC's redesign priorities include: 1) delivering direct clinical services efficiently and with extra attention to defining service gaps; 2) improving and systematizing statewide care coordination services for CSHCN; 3) facilitating and supporting development and spread of the medical home model among Iowa's primary care providers; and 4) maintaining a strong and participatory parent-consultant network as the core of Iowa's Title V CHSCN family participation program. //2010//***

/2008/A newly identified gap filled by CHSC involves the administration and management of selected Title V MCH community-based child health centers. Although not a typical responsibility of the Title V CSHCN Program, this gap-filling activity may enhance local MCH/CYSHCN program partnerships. /2008/

The process for developing CHSC priorities uses a combination of structured problem identification and prioritization activities, web-based public input opportunities, and program leadership strategic planning efforts. In formulating program priorities, consideration is given to national priorities, emerging issues, financial circumstances, collaborative opportunities, and overall environmental fluctuations. Input into program planning decisions is sought from CHSC program staff, state and community-based MCH stakeholders, and families of CYSHCN. Legislators, though generally not involved in program planning, are kept informed of major program activities that benefit their constituents. Program planning and priority setting has been supplemented by data from the 2000 Iowa Child and Family Household Health Survey and the National Children with Special Health Care Needs Survey (2001). Both are random sample, population-based surveys that are scheduled to be repeated in the next year or two. Repeated survey administration will provide information about changes in family experiences over time. In keeping with current high-level interest in early childhood health and development, the next version of the Iowa Child and Family Household Health Survey, scheduled for 2005, will have a special focus on early childhood issues. /2007/ Data from the 2005 Iowa Child and Family Household Health Survey has been collected and is in the process of being summarized by the contracted agency, the University of Iowa Public Policy Center. Data review and interpretation by Title V CYSHCN and MCH staff will begin later this summer. /2007/

/2008/ The 2005 Iowa Child and Family Household Health Survey has now been completed and summarized. This provides new cross-sectional and some longitudinal data for program planning. /2008/ /2009/ The 2006 National CSHCN Survey data has been released. This data will now be used in conjunction with the 2005 Iowa Child and Family Household Health Survey data to further enrich understanding of Iowa family experiences caring for their CSHCN. /2009/

The population-based surveys, in combination with the problem identification and prioritization activities, have identified a number of issues important to CYSHCN and their families. Consistent with national priorities, these include child and adolescent mental and behavioral health; medical homes for CYSHCN; organization and coordination of services for families; early identification and referral; transition systems for adolescents with special health care needs; family involvement

in program activities; and adequate coverage for needed services. Underlying all these issues is a continuing challenge to define CHSC's roles in addressing identified priorities in a limited resources environment. Possible roles, for example, include leadership, facilitation, participation, direct service provision, resource support, and advocacy. /2007/ One new method to more effectively address priorities for Iowa's CYSHCN involves CHSC's direct participation in the official budget request process used by the executive branch to guide its own budget priorities. /2007/ /2009/ Another important avenue for representing CSHCN-related public health priorities at the state level involves having CHSC staff on state boards. CHSC staff are now members of the State Board of Health, the State Empowerment Board (target population is 0-5 year olds), and the Governor's Medical Assistance Advisory Board (target population is Medicaid recipients). /2009/

More and more, CHSC self-identifies as an organization dedicated to infrastructure building for the purpose of system development. Infrastructure building efforts currently receiving the greatest attention include improving access to pediatric mental and behavioral services and spreading the medical home model to improve quality of care for CYSHCN. /2007/ CHSC is also seeking to more clearly define and document the important function of care coordination, as well as to standardize the competencies expected of any staff member providing care coordination services. /2007/ ***/2010/ Greater focus on defining and assuring care coordination competencies, and systematically matching competencies to patient and family needs is now occurring under the guidance of a new CHSC "medical home - care coordination task force." //2010//*** To assure success in system development, CHSC is incorporating program evaluation, health services research, economic analysis, and partnership building strategies -- all with an eye to positively influencing policymakers.

/2008/ Pertinent examples include: 1) participation in Iowa's Part C Early Childhood Outcomes measurement efforts; 2) membership on the evaluation planning team for a new SAMHSA-supported children's mental health system development effort; and 3) more deliberate quality improvement activities to assure minimum quality standards across all CHSC regionally-based Birth to Five Programs. /2008/ /2009/ With respect to quality improvement efforts, CHSC is currently in the midst of a continuing education activity to teach all program leaders and coordinators the fundamental application of rapid cycle change strategies to accomplish process improvement. /2009/

/2010/ Also, additional focus in the Title V CSHCN Program is being given to health service delivery and health status outcome issues related to cultural diversity. Cultural brokering, cultural diversity technical assistance, and culturally-relevant social determinants of health-related policy are all receiving new or increased emphasis in CHSC's program planning and implementation activities (see several examples in the CYSHCN part of the Agency Capacity section). //2010//

B. Agency Capacity

In Iowa, Title V administration is the joint responsibility of the Bureau of Family Health (BFH) at the IDPH and Child Health Specialty Clinics (CHSC) at the University of Iowa. Iowa's MCH programs promote the development of systems of health care for children ages zero to 21, pregnant women, and their families. Iowa strives for services that are collaborative, comprehensive, flexible, coordinated, culturally competent, developmentally appropriate, family-centered and community-based. The core public health functions of assessment, policy development, and assurance are promoted.

Preventive and Primary Care for Pregnant Women, Mothers, and Infants
The Women's Health Team provides direction, oversight, and monitoring for the 30 local maternal health and/or family planning contract agencies. Systems development activities are coordinated

with the IDPH Family Planning Program, the Family Planning Council of Iowa, hospitals, schools, local boards of health, providers of adolescent health programs and statewide women's health initiatives. Technical support is provided to local MH and FP agencies. Contracts are managed with the University of Iowa Hospitals and Clinics (UIHC), Department Pediatrics. The MH Community Health Consultant coordinates activities with the Healthy Start Project managed by Visiting Nurse Services of Polk County.

The 24 local MH contract agencies provide services to all 99 counties. The map of local MH contract agencies is located at http://www.idph.state.ia.us/hpcdp/common/pdf/mh_map.pdf. Local MH agencies provide prenatal and postpartum care to low-income women and other women in need. Services include risk assessment, psychosocial screening, referrals, care coordination, education, delivery planning, postpartum visits and presumptive eligibility for Title XIX. Outreach efforts include community-based strategies for hard to reach populations, with special emphasis on informing clients of available services. Modes of delivery of the medical components of prenatal care include clinic settings, purchase of services from private practitioners, and agreements with local hospitals. Performance standards have been developed to ensure the provision of quality maternal health service throughout the state. MH Agencies also complete a Quality Assurance Matrix evaluating the provision of enhanced services and conduct direct care chart audits on an annual basis.

The Statewide Perinatal Care Program provides training of health care professionals, development of care standards, consultation for regional and primary providers, and evaluation of quality of care through the state's 82 hospital facilities that provide obstetrical and newborn services. The team consists of a neonatologist, a perinatologist, a dietitian, an ob nurse, and a neonatal intensive care nurse. Through a contract with the University of Iowa Hospitals and Clinics, these services are provided to all hospitals that perform deliveries; more intensive services are directed toward Iowa's three tertiary care centers and 19 secondary care centers. Quarterly, the team also publishes two newsletters: "The Iowa Perinatal Letter" for health care providers and "The Progeny" for perinatal nurses. The publications are used for general prenatal education and to disseminate information.

Des Moines Infant Mortality Center Consortium

The mission of the Consortium is to improve birth outcomes and to reduce infant mortality by enhancing maternal child health interventions to vulnerable populations. One of the consortium goals is to enhance partnerships between state and local government, maternal and infant health care providers, and the private and public sector to provide integrated community-based care for pregnant women and their infants. The consortium includes physicians, nurses, social workers, community leaders, and legislators. The consortium is a collaboration between the IDPH, Visiting Nurse Services of Polk County and Healthy Start. The VNS of Polk County holds the Healthy Start Grant to Eliminate Disparities in Perinatal Health. Strategies include outreach and recruitment efforts directed toward identifying and engaging pregnant women in services in the first trimester, family development, home-based case management, health education, depression screening, and community support services. All vulnerable minority populations are included in the targeted population for the Polk County Healthy Start Program; however, a specific emphasis was placed on the African American and Hispanic/Latino populations due to infant mortality rates in the identified project area. The consortium continues to work with Polk County Healthy Start to continue to address the significant disparities in infant mortality.

Abstinence Education

IDPH applied for federal funding through Section 510 and Community Based Abstinence Education (CBAE), formerly SPRANS, of Title V of the Social Security Act. Section 510 will secure contractors through a competitive Request for Proposal (RFP) to provide abstinence education programming throughout the state. Programming may include curriculum-based programs, community involvement, mentoring, media campaigns, positive youth development, informational programs, parent involvement, and peer education. CBAE will fund three community-based agencies, selected through an RFP, to provide programming through

curriculum-based instruction, community involvement and mentoring components.

/2007/ IDPH applied to the DHHS, for funding through Section 510. Through an RFP, IDPH contracted with eight local agencies to provide abstinence education programming. IDPH will also submit a competitive CBAE application to the Administration for Children and Families. /2007/

/2008/ IDPH applied to the DHHS, Administration for Children and Families for funding through Section 510. Through a continuation RFA, IDPH contracted with eight community-based agencies to provide abstinence education programming. The University of Iowa conducts a program evaluation that assesses Iowa's progress towards achieving the abstinence education performance measures. /2008/

/2009/ IDPH continued its participation in the Section 510 Abstinence Education Program through June 30, 2008. IDPH continued to operate on federal extension funding, providing continuation funds to seven community-based agencies and the University of Iowa for program evaluation. In March 2008, Governor Culver announced IDPH would no longer be authorized to accept Title V, Section 510 funds effective June 30, 2008. As a result the department did not renew current Section 510 contracts. /2009/

/2010/ As the Section 510 Abstinence Education Program in Iowa ended June 30, 2008; no abstinence education activities are being implemented in FFY09. If reauthorization or extension occurs, Iowa will re-evaluate the Section 510 program if the A-H guidelines are significantly modified. //2010//

Preventive and Primary Care for Children
Members of the Child Health Advocacy Team(CHAT) have extensive experience working with child and adolescent health issues. The team provides direction and oversight to 23 local CH agencies covering all 99 counties. Program activities include cooperative efforts with the Oral Health Bureau, Bureau of Disease Prevention and Immunization, Bureau of Lead Poisoning Prevention, Bureau of Nutrition and Health Promotion, Center for Congenital and Inherited Disorders, Early ACCESS (IDEA, Part C), Early Hearing Detection and Intervention, Empowerment, Early Childhood Iowa, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Adolescent Health, Family Planning, Healthy Child Care Iowa, Healthy Mental Development, Covering Kids and Families, hawk-i Outreach, Head Start and the Asthma Control Program.
/2007/ CHAT advocated for a quality performance measure using lead screening as a proxy indicator. The team collaborates with the IDPH Bureau of Lead Poisoning Prevention to monitor state data; match STELLAR with relevant data sets to determine whether children have been tested; promote comprehensive screening services that include lead testing within medical homes; promote referrals for appropriate testing and follow-up services; and provide ta to MCH agencies regarding lead testing as a component of comprehensive child health services. /2007/ /2008/ CHAT focused on promoting timely immunizations for Iowa's children. The team collaborates with Medicaid and the IDPH Immunization Program to review state data; provide updated information on immunizations; provide consultation to MCH agencies regarding use of Immunization Registry Information System; promote enrollment in IRIS among private providers; promote referrals for immunizations through care coordination services; and provide information through the EPSDT newsletter on new vaccines and recommended practice. /2008/ /2009/ CHAT had two primary areas of focus. A core group of consultants that provide TA to CH contract agencies meet every other month. This group addresses issues pertaining to contract management. The broader CHAT group meets on alternate months and continues to provide a forum for communication and collaboration across IDPH programs that impact children. /2009/

/2010/ The CH Team (CHAT) addressed program development issues related to IDPH becoming fee-for-service payers of informing services for families of Medicaid newly eligible children and care coordination services for both Medicaid and non-Medicaid children through a Medicaid administrative services agreement with the Iowa Medicaid

Enterprise. Parameters for quality assurance review of claims through an electronic record system were developed. The team provides a forum for facilitating communication and collaboration across programs that impact children. //2010//

Local CH contract agencies are charged with developing health programs that are responsive to the needs of the community. The MCH Performance Standards described previously are used to ensure the provision of quality CH services throughout the state. The CH agencies focus on infrastructure building, population-based services, and enabling services to assure that children have access to well child screening services. Other activities of contract agencies include outreach for uninsured children, education and refferals to families about for services, assuring medical homes, providing direct care services where access is limited, improving oral health access, promoting health and safety in child care settings and coordinating with Early ACCESS. /2007/ The map of local CH agencies is located at http://www.idph.state.ia.us/webmap/default.asp?map=epsdt. /2008/ Each contract agency continues to implement plans to address priority needs within their service area. Initiatives include a series of trainings for local agency staff in the role of service coordination for the Early ACCESS (Part C) program. /2008/ /2009/ Each contract agency continues to implement plans to address priority needs within their service area. Due to an Office of Inspector General Targeted Case Management Audit and changes in Iowa Medicaid rules for service documentation, special emphasis has been placed on quality assurance/ quality improvement pertaining to documentation and delivery of services. Each local agency is required to have a quality assurance plan that addresses internal review of service documentation. IDPH also conducts quality assurance review of documentation based upon a random sample of Medicaid paid claims. /2009/

/2010/ Each local MCH contract agency continues to implement plans to address priority needs within their service area to the degree funding is available. Agencies struggle to align services with available funding. Significant decreases in Title V funding that began in FFY06 were realized at the local level in 2009 as previously available carryover funds were fully expended. Prioritizing needs and services is the central focus of FFY10. //2010//

Oral Health Program: The Oral Health Bureau (OHB) promotes access to dental care and preventive health behaviors to reduce the risk of oral disease. In addition to administering programs such as the school fluoride mouth rinse, school-based dental sealant, and dental care for persons with disabilities, the OHB staff offers consultation and assistance to MCH agencies in assuring good oral health for the women and children they serve. Local CH contract agencies receive funding to be used in three ways: to provide limited preventive and restorative dental care for their uninsured or underinsured clients through agreements with local dentists; for infrastructure-building activities; and to pay for costs associated with dental hygienist services. Local CH contract agencies also receive money for the Access to Baby and Child Dentistry (ABCD) program, to be used to improve oral health status and increase access to dental homes for Medicaid-enrolled children. MCH clients receive direct preventive care from dental hygienists in more than half of Iowa's 99 counties.

OHB staff also collaborates with several private and public organizations to improve access to oral health care. Partners include the University of Iowa College of Dentistry, Delta Dental Plan, the Iowa Dental Association, the Iowa Dental Hygienists' Association, the Head Start Association, DHS, the Iowa-Nebraska Primary Care Association, the Iowa Rural Development Council, the University of Northern Iowa and the Iowa Prevention of Disabilities Policy Council. /2007/ The OHB will continue to seek additional partnerships and funding to work toward improved oral health of at-risk Iowans. The OHB is also overseeing two community projects to improve access to children's oral healthcare. One project is developing a local coalition to attract dentists to its rural area; the other is training local healthcare providers on oral assessments. /2007/ /2008/ In FFY08, the OHB continues to collaborate with the Department of Human Services (DHS). DHS supports the I-Smile project, implemented through CH agencies, with the goal of assuring dental homes for Medicaid-enrolled children. A new state mandate that children have a

dental exam or screening prior to school enrollment will create opportunity for the OHB to work more closely with the Dept of Education./2008/
/2009/ Additional funding for I-Smile during FFY09 has been requested, to be used for increasing infrastructure at both state and local levels. Funds have also been requested to increase primary prevention (fluoride varnish, sealants) at the local level, particularly for children ages 6 and younger. OHB staff will continue to work with local contractors, Early Childhood Iowa, DHS, and many other partners in order to create service systems to ensure access to oral health for families served. OHB will continue to collaborate with Delta Dental of Iowa and the IDPH Division of Environmental Health for a community water fluoridation grant project. The grant will provide both funding and technical support to communities seeking to start water fluoridation activities. OHB will maintain its support of education opportunities for primary care providers.

A contract between OHB and the University of Northern Iowa's Center on Health Disparities will assist in assuring culturally appropriate health promotion. /2009/

/2010/ A partnership between OHB and DHS will result in continued funding for the I-Smile™ dental home initiative. Data analyzed after the first 18 months of I-Smile™ shows marked improvement in access to preventive dental services for underserved children. The increase in preventive care is occurring through local CH agencies and medical practitioners. As a result, OHB will continue to pursue relationships with medical provider organizations and participation with the state's medical home initiative. The school dental screening requirement enacted by the 2008 General Assembly has resulted in increased collaboration with school nurse organizations and local public health partners and will provide OHB with additional data to assist in program planning.

A Targeted Oral Health Service Systems grant through HRSA is helping OHB to promote oral health statewide. OHB now offers information about I-Smile™ and children's oral health is available through a Web site, toll-free phone line, and printed education materials (e.g. posters, first birthday postcards). A new public-private partnership with Delta Dental of Iowa Foundation is conducting two public service announcements (PSAs) in a television test market this year. OHB will measure impact of two public service announcements to determine if they would be effective for a statewide audience next year. //2010//

Healthy Child Care Iowa: Iowa has 79 child care nurse consultants (CCNC). Training is offered annually to registered nurses entering a consultant role with early care and education businesses. Five full-time regional CCNCs have communication and mentoring responsibilities for the part-time CCNCs in their region. Funding for CCNC positions comes from Child Care Developmental Funds, Empowerment funds, and Head Start/Early Head Start. Iowa's Title V grants to local MCH agencies require the local agency to support a registered nurse as 0.5 FTE child care nurse consultant. Agencies use a variety of strategies to fulfill this requirement. CCNC conduct on-site assessments and technical assistance, training, and respond to requests for information. An encounter-based activity logging system was field-tested. Quality improvement instruments were completed, field-tested, and readied for dissemination.

/2007/ Iowa offers CCNC services to child care businesses through local child health agencies. The CCNCs conduct on-site assessments of health and safety and offer technical assistance and training in response to findings. The CCNC record encounters with child care businesses using the CCNC encounter-based activity recording system. /2007/

/2008/ Iowa has 66 CCNCs working a total of 25 FTEs. The number of CCNC has decreased, but the number of FTE has increased. CCNC involvement in the Iowa Quality Rating System (QRS) continues. The QRS nurse activities are a business partnership agreement; initial child care survey of 25 items; injury prevention checklist of 40 items; child record review -18 items; and a health and safety assessment which reviews written policy and provider practices. Iowa offers two child care nurse consultant trainings per year, four optional continuing education sessions; and

one required meeting. /2008/

/2009/ Iowa has 70 CCNCs filling 28 FTE positions. Initial training for CCNC is offered twice a year. The CCNC training contains a classroom didactic portion with field study. Child care business involvement in the Iowa Quality Rating System grows. Health and safety are included in the QRS assessments. Program fidelity remains a priority for CCNC. The major areas of concern are control and prevention of communicable disease and injury prevention. /2009/

/2010/ Iowa has 62 CCNCs working a total of 31 FTE positions. Initial training for CCNC is offered three times a year. The CCNC training didactic portion is conducted through structured distance learning, with onsite practicum experiences and a four day face to face application of didactic content, skills demonstration and additional practicum experiences. Child care business involvement in the Iowa QRS grows. Health and safety are included in the QRS assessments. Program fidelity remains a priority for CCNC. The major areas of concern continue to be control and prevention of communicable disease, and injury prevention. //2010//

Child Death Review Team: The Iowa Child Death Review Team (CDRT) reviews medical, investigative, and medical examiner records of all Iowa children from birth through 17 years of age who died during the previous calendar year. CDRT recommendations to prevent future deaths are made annually to the Governor, legislature, state agencies, and the public. /2008/ CDRT partners with Blank Children's Hospital in Des Moines to host a conference on child death. /2008/

/2010/ In FFY10, the CDRT plans to partner with Blank Children's Hospital in Des Moines to host a conference on child death prevention. The CDRT also plans to collaborate with agencies to disseminate collected data to a broader audience, including the public and policymakers. In the 2009 General Assembly, CDRT responsibilities moved from BFH/Title V to the Medical Examiners Office. BFH staff worked with the Medical Examiners Office to transfer the program. //2010//

Sudden Infant Death Syndrome Program: Autopsies are required by Iowa Code on all children two years and younger who die unexpectedly. A contractual agreement with the Iowa SIDS Foundation covers printed information, community and professional presentations, grief counseling, and referral services. A peer contact provides assistance to the family through the first year of grief following the infant's death. The Iowa SIDS Foundation operates eight grief support groups across the state.
/2010/ The contractual agreement with the Iowa SIDS Foundation is expected to continue in FFY2010. //2010//

Center for Congenital and Inherited Disorders
In 2004, state legislation was passed that renames the Birth Defects Institute and some of its programs. The Institute is now called the Center for Congenital and Inherited Disorders (CCID). Programming from the CCID includes: Iowa Registry for Congenital and Inherited Disorders Regional Genetic Counseling Services, Iowa Neonatal Metabolic Screening Program (INMSP), Maternal Serum Alpha-fetoprotein (MSAFP) screening program, and the Neuromuscular and Related Disorders program.

With the possible addition of cystic fibrosis carrier screening as part of the MSAFP, and cystic fibrosis screening as part of the INMSP, the genetics program staff has been working closely with the Pulmonology and Allergy Department staff at the University of Iowa.

The Center is also participating in the Heartland Regional Neonatal Screening and Genetics Collaborative that serves eight states in the Midwest. The Center is promoting the U.S. Surgeon General's Family Health History initiative through presentations and public service campaigns.

/2007/ The CCID now provides oversight for seven programs: the Iowa Registry for Congenital and Inherited Disorders (IRCID), the Regional Genetic Consultation Service, the Iowa Neonatal Metabolic Screening Program (panel now includes cystic fibrosis), the Maternal Serum Alpha feto-protein screening program, the Neuromuscular and Related Disorders program, the Iowa Stillbirth Surveillance Project and prevention activities, and the Family Health History Initiative./2007/ /2008/The CCID has established an "executive team" to review policies, procedures, standards, and needs of the newborn screening program. /2008/ /2009/ The CCID continues all of the above activities, and additionally is working to: address genetic discrimination through policy development; promote stillbirth awareness; provide information to consumers regarding family health history; develop a newborn metabolic screening business process analysis document; and explore the addition of Severe Combined Immune Deficiency (SCID) to the newborn screening panel. /2009/

/2010/ The CCID has developed a code of ethics to guide decision-making and policy development. Stillbirth prevention activities continue along with the stillbirth surveillance program at the IRCID. The registry has been expanded to conduct surveillance of confirmed newborn screening cases. CCID continues to increase family and health provider participation in the planning, implementation, and evaluation of the newborn screening programs through the Iowa Family Participation Project, via a HRSA MCHB cooperative agreement. The newborn screening coordinator, a shared position with North Dakota, has been added to the executive team. This position is responsible for quality assurance, education and strategic planning for Iowa and North Dakota newborn screening programs. //2010//

Early Hearing Detection and Intervention
The state's Early Hearing Detection and Intervention (EHDI) efforts are directed by the IDPH and CHSC. IDPH has entered into a new three-year cooperative agreement with the Centers for Disease Control and Prevention to improve the state's capacity to collect and track hearing-related information for children zero to three. CHSC entered into a three-year EHDI grant with MCHB. The purpose of the MCHB project is to assure that all infants and toddlers who are identified as deaf or hard of hearing receive timely and appropriate follow-up services.

/2007/ IDPH and CHSC are collaborating to implement the electronic reporting system in birthing hospitals and to improve access to appropriate follow-up hearing services. /2007/ /2008/ IDPH and CHSC implemented the electronic reporting system in all birthing hospitals and the Area Education Agencies. /2008/ /2009/ IDPH and CHSC are developing policies, procedures, and protocols for the EHDI system. The document will be distributed to birthing hospitals and audiologists throughout the state as the focus turns to quality assurance with reporting and follow-up services for children who are deaf or hard-of-hearing. /2009/

/2010/ IDPH and CHSC are conducting site visits at all birth facilities to gain a better understanding of each hospital's EHDI program, ensure compliance with Iowa law and administrative rules, identify strengths and needs of the individual program, share best practices and develop a more clear understanding of the technical assistance needs of hospital based newborn hearing screening and follow up programs. //2010//

Iowa Collaboration for Youth Development (ICYD)
The Collaboration is a partnership of state and local entities concerned about youth and youth policies. This interagency initiative is designed to better align state policies and programs and to encourage collaboration among multiple state and community agencies on youth-related issues. The goals of the initiative are to promote the use of positive youth development principles in state policies and programs and to facilitate the use of effective youth development practices in communities.

The Interagency Steering Committee for the ICYD has endorsed the concepts and principles put forth in the design for "Enhancing Iowa's Systems of Supports for Learning and Development".

This document introduces a set of new concepts for systems of supports that students need if they are to achieve at high levels.

/2007/ The ICYD continues to play an active role in supporting the DE in its learning supports initiative. /2007/ /2009/ The ICYD issued a Healthy Youth Data Brief in March of 2008. The report is the fourth in a series of data briefs covering the youth development framework indicators developed by the ICYD. /2009/

Improving Academic Achievement by Meeting Student Health Needs
The Iowa Interagency Health Promoting Communities and Schools team developed "Improving Academic Achievement by Meeting Student Health Needs". The purpose of the briefing was to gather scientific-based research supporting school health promotion to improve academic achievement.

/2008/The IHPSC team reviewed the Community School Improvement and site visit process of the Dept of Education and did not find an integrated health component. Since significant health needs of children affect their achievement, the IHPSC team recommended that districts compile health information with achievement data to help determine areas of impact that can improve child performance. /2008/

/2010/ DE, DPH and DHS renewed their interdepartmental agreement to advance initiatives in coordinated school health. The Departments agreed to continue coordination of the statewide infrastructure to organize existing school health programs. Priority actions are being addressed to improve student health and academic outcomes. Prioritizing school health programs advances the missions of each Department. The first goal of the interagency collaboration is to focus on school wellness. The Joint Statement and team members can be found at http://www.iowa.gov/educate //2010//

Prevention of Youth Violence
Iowa's primary focus is to strengthen prevention of self-directed and interpersonal child and adolescent violence. These include such behaviors as suicide, child maltreatment, school violence, community violence and bullying. Comprehensive and sustained support of youth is necessary to improve youth outcomes and reduce suicide and interpersonal violence. The overarching theme of the violence prevention effort will be youth development. Youth development goes beyond problem reduction and applies to prevention, remediation and treatment, participation and involvement, and academic and workforce preparation.

/2008/ IDPH recently received notification of SAMHSA Garret Lee Smith grant funding for suicide prevention. STIPDA State Technical Assistance Team conducted an assessment on IDPH injury and prevention activities. /2008/ /2009/ In July 2007, IDPH was given $1.2 million for a three-year suicide prevention project. The focus is on suicide prevention activities for adolescents ages 15 - 24. The Columbia Teen Screen will be used as the model.

Following receipt of the report from the STIPDA State Technical Assistance Team visit, the Executive Team approved IDPH to move ahead with the recommendation to complete a comprehensive injury report. The Bureau of Disability and Violence Prevention has taken the lead in this initiative, but is working with data analysts from the Bureau for Health Statistics, EMS and DOT to complete the report. /2009/

/2010/ IDPH completed the first comprehensive report on the Burden of Injury in Iowa in December 2008. This report follows recommendations from the CDC National Center for Injury Prevention and Control for data elements included. In addition, partners at the U of I Injury Prevention Research Center completed county level reports for Iowa counties on injury deaths and hospitalizations.

IDPH Adolescent Health Program is participating in the development of a strategic plan for

sexual violence prevention in Iowa. The work of the Iowa Sexual Violence Prevention Planning Committee is guiding the process of assessing and identifying strategies for the prevention of first-time perpetration and victimization of sexual violence in Iowa. //2010//

Culturally Competent Care for MCH Populations
The Office of Minority Health was renamed to the Office of Multicultural Health (OMH) and remains under the Division of Health Promotion and Chronic Disease Prevention. The Office continues to increase the capacity to provide training to MCH agencies on cultural diversity/sensitivity and health disparities and educational awareness workshop presentations at local and statewide MCH related conferences and seminars.

The OMH consultant serves as a resource person for IDPH programs, especially those programs with strategies, goals and objectives to address the needs of women, children and families of minority, immigrant and refugee populations. Resources include educational materials, outreach, and networking to access services, community stakeholders and networks and curriculum training design and instruction.

The Minority Health Advisory Board is currently being examined for reactivation. Although it recently has not formally met due to restructuring of IDPH advisory boards, the OMH consultant continues to communication and networking with representatives from the African American, Latino, Asian/Pacific Islander, Native American, refugee and immigrant populations.

The OMH entered into agreement with the Polk County Minority Health Coalition Infant Mortality Subcommittee and produced the Polk County Health Infant Mortality video specifically targeted to decrease the disproportionate rates of infant mortality in the African American community. /2008/ In 2007 the Office of Multicultural Health received funds for infrastructure building. A five year strategic plan for FY 2007 --FY2011 was completed. /2008/

/2009/ In 2008 the OMH received grant funds for a one-day African American female youth summit. The summit targeted young ladies ages 14 to 18 and addressed self-esteem building, positive life-style choices and HIV/AIDS and STD awareness. The summit provided an essential mechanism towards efforts to decrease disparities through educating young African American women on the impact of risky lifestyles and choices and the impact on their health and their community. It is the intent of OMH that this summit approached be utilized by all diverse populations of females within this age group and replicated around the state. /2009/

/2010/ The OMH invited 21 representatives, key informants throughout the State of Iowa and five state personnel to help chart a strategic map for the OMH staff and its constituents to implement during the next three to five years as the office strengthens its infrastructure and continues to meet its mission. //2010//

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS
Child Health Specialty Clinics (CHSC) uses an organizational structure of 13 ***/2010/ 14 //2010//*** regional centers to provide family-centered, community-based, coordinated services to Iowa children and youth with special health care needs (CYSHCN) and their families.

Direct Clinical Services
The Integrated Evaluation and Planning Clinic (IEPC) is CHSC's cornerstone direct clinical service. It is a multidisciplinary service located in all CHSC regional centers, except Iowa City and Des Moines. The IEPC primarily evaluates and makes recommendations for children with behavioral and emotional problems. IEPCs are an important platform for family access to intensive care coordination, as well as to child psychiatry consultation via telehealth communication. IEPC staffing includes some or all of the following: an advanced registered nurse practitioner or nurse clinician, a contracted medical consultant, an Area Education Agency psychologist and/or speech and hearing professional, a contracted or DHS social worker and a parent consultant. Most children seen in an IEPC have complex behavioral or emotional

problems that are not successfully addressed by parents, educators, or primary care physicians. The IEPCs provide a cost-effective resource to evaluate and monitor treatment within local communities. /2007/ An IEPC program evaluation revealed that local discretion produced a non-standardized, irregular clinical service that sometimes failed to meet current practice standards. Therefore, CHSC is now standardizing the referral, staffing, diagnostic, therapeutic and follow-up processes for the IEPC service across regional sites. /2007/

The Birth to Five Program is CHSC's clinical contribution to Iowa's early childhood system. Birth to Five services are located in all CHSC regional centers. Birth to Five provides developmental screening, assessment, and follow-up for young children at-risk for developmental delay. Recommendations and family support are provided, as is care coordination, if needed. Advanced registered nurse practitioners with expertise in care and management of young children with special health care needs are the providers. Birth to Five collaborates with Iowa's Part C Program and local primary care providers. Children served by Birth to Five include those at risk for developmental delay in growth, motor skills, language, and social interaction; children subjected to abuse or neglect; and children exposed to drugs during pregnancy or later at home. /2008/ The Birth to Five Program is undergoing an in-house evaluation to document clinical and care coordination processes and to assess the progress and outcomes for children ages 0-5. /2008/ /2009/ As of mid-2008, all CHSC regional Birth to Five clinics added a new service - autism screening for young patients at risk for developmental delay. /2009/

/2010/ The IEPC and Birth to Five Program direct services have been combined to form a more generic service called "CHSC Clinical Programs." //2010//

/2009/ Effective in FY08, the Iowa Department of Education contracted additional funds for CHSC to provide nutrition consultation services to young children enrolled in Iowa's Part C early intervention program. /2009/

/2010/ CHSC's Regional Autism Services Program (RASP) reports a doubling of the number of autism spectrum disorder screenings of children 18-36 months seen in CHSC clinic settings. //2010//

Care Coordination Services
CHSC's Health and Disease Management (HDM) Unit, composed of both nurses and parent consultants, is designed to help families evaluate a child's needs and obtain services. Since 1985, CHSC has had an agreement with the Iowa Dept of Human Svc (DHS) to assist with care coordination of CSHCN eligible for the Medicaid Ill and Handicapped Waiver. Now, care coordination is provided for children enrolled in Medicaid's consolidated Waiver Program. The number of CSHCN enrolled in Waiver programs served by CHSC's HDM Unit depends on the amount of Medicaid funds available.

General care coordination is also available for CSHCN and families enrolled in the direct care IEPCs or Birth to Five Program. For children with significant behavioral health problems, an intensive care coordination effort is being offered.

The Continuity of Care Program is a care coordination service to improve linkages and outcomes for CSHCN discharged from the Children's Hospital of Iowa (at the University of Iowa) to community-based services. /2008/ The Continuity of Care Program is now administered and financially supported by the University of Iowa Children's Hospital. CHSC continues to provide office space for the program's staff. /2008/

A major new care coordination initiative will facilitate linkages of all primary care practices in the state -- pediatric and family medicine -- to community-based care coordination resources, most of which will be affiliated with the Title V Program. This initiative is part of an MCHB-supported Integrated Community Systems (ICS) grant. ***/2010/ This particular initiative is a high priority for CHSC and is already continuing beyond the termination of the ICS grant. //2010//***

/2008/ A successful pilot has motivated Iowa's Part C Early Intervention Program to provide support to selected members of CHSC's Parent Consultant Network to function as service coordinators for medically complex children ages 0-3, enrolled inEarly ACCESS. /2008/ /2009/ Effective in FY08, the Iowa legislature appropriated additional funds for CHSC to expand its service coordination capacity for Early ACCESS enrollees with conditions of prematurity, early drug exposure, or medical complexity. /2009/ ***/2010/ Additional Part C funds, originating from ARRA stimulus, will be appropriated to CHSC for service coordination. //2010//***

Family Support Services
The CHSC Parent Consultant Network (PCN) is affiliated with the CHSC regional centers and utilizes parents of CYSHCN to serve as community-based consultants to other parents and families. Two family participation coordinators, both PCN members, function as leaders who work to assure family participation in all aspects of program planning and policy development. They also provide family participation data, explore resources, participate in needs assessments, develop training materials, promote collaboration and organize family advocacy efforts.

Families play a large role in system development activities. For example, there will be a faculty member of the 2005 statewide learning collaborative who will provide content and guidance to primary care providers seeking to improve the family-centeredness of their practices. /2007/ With reference to 2006 Chronic Care Improvement (Medical Home) Learning Collaborative, participating primary care practices are given a family perspective to motivate quality improvement efforts relevant to family interests and experiences. A CHSC PCN co-leader is now a permanent member of the ICS grant planning group. /2007/ /2009/ In FY08, a longstanding PCN member accepted an offer to serve on the statewide Governor's Medical Assistance Advisory Committee. /2009/
Families of CYSHCN are able to use the Toll-Free Hotline as a statewide information resource.

/2010/ A new Family-to-Family Health Info Center grant will enhance the mentoring, resource sharing, and parent-professional partnering of CHSC and other family advocacy efforts. //2010//

Infrastructure Building Services
CHSC is increasingly involved with a variety of activities to improve service system quality and capacity. CHSC is a leader and participant in efforts to both improve program-specific operations and meet larger scale community and state needs. The CHSC Policy and Planning Unit is the organizational structure that guides and facilitates CHSC's infrastructure building activities. The fundamental core public health functions of assessment, policy development, and assurance have been strengthened in the programmatic and environmental awareness of leadership staff. /2009/ A new leadership training effort will involve teaching CHSC staff the fundamentals of rapid cycle change techniques to build an orientation toward problem identification and continuous quality improvement. /2009/ ***/2010/ The CHSC Policy and Planning Unit has been renamed the "CHSC Public Health Division" to better emphasize its foundational responsibility to assure the quality of our Title V program at all levels of the MCH pyramid. //2010//***

Examples of CHSC infrastructure building efforts include: evaluation of clinic services; development of a new model to expand access to pediatric mental health services; hypothesis generation and testing using population-based survey data; implementation and evaluation of the medical home and adolescent transition projects; and collaborative systems planning with stakeholders in the SECCS project and the Assuring Better Child Health and Development project. CHSC also partners in system development efforts with the Early ACCESS program, the Governor's children's mental health system redesign effort, /2007/ and the IDPH-sponsored Safety Net Provider Network. /2007/ /2009/ CHSC is partnering in IDPH-based efforts to improve early childhood developmental screening and to create medical homes for all Iowans. CHSC is also partnering with the Iowa-Nebraska Primary Care Assoc to provide technical assistance to safety net providers (e.g. free clinics, MCH agencies, local boards of health and community

health centers) interested in incorporating medical home elements into their service structures. /2009/

/2010/ A portion of federal ARRA funds distributed to CHSC through Iowa's Early ACCESS program will be used to document and modify the social determinants of health (SDOH) that increase the risk of negative outcomes for Iowa's early childhood population. //2010//

/2010/ Cultural Competence Initiatives

CHSC will be increasing attention to cultural diversity and cultural competence in several major program areas:

1) The Early Hearing Detection and Intervention project will hire a .25 FTE cultural broker to advise on follow-up issues for minority children identified with hearing loss.

2) A new Hispanic Part C service coordinator will be hired in N.W. Iowa to serve eligible young Hispanic children and their families.

3) A white paper on social determinants of health, including issues of cultural diversity, will be produced to encourage policies promoting healthy outcomes for all of Iowa's early childhood target population.

4) A new cultural broker for the SAMHSA system of care mental health project will focus on inclusion for Iowans living in rural poverty.

5) The Family-to-Family Health Info Center project will identify and address cultural and linguistic competence technical assistance needs for its family information-sharing and mentoring initiatives. //2010//

C. Organizational Structure

The Iowa legislature designated the Iowa Department of Public Health (IDPH), a cabinet level agency, as the administrator for Title V and maternal and child health (MCH) services. The legislature also directs IDPH to contract with Child Health Specialty Clinics (CHSC) based at the University of Iowa Department of Pediatrics, as the state's Title V services for children and youth with special health care needs (CYSCHN) program. Statutory authority identified in the Code of Iowa (Chapter 135, Iowa Administrative Code 641, Chapter 76) provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified in House File 737 of the 2000 Session of the Iowa General Assembly. Contracts between IDPH and CHSC outline the responsibilities of both agencies for fulfilling the mandate for maternal and child health services. Copies of the contracts are available upon request. Additional State of Iowa statutes relating to MCH and CYSCHN programs are listed in the attachment.

The IDPH Division of Health Promotion and Chronic Disease Prevention includes the Bureau of Family Health (BFH), the primary MCH unit within the state. Responsibility for the administration of the Title V Block Grant lies within the BFH. Tables of organization illustrate the relationship of the division and the bureau within IDPH. It can be found in the Appendices. The bureau also administers a portion of the state's Title X Family Planning services. The organizational structure of the Bureau of Family Health has remained stable in recent years, while IDPH itself has experienced organizational change. Mary Mincer Hansen, RN, PhD was appointed as director of IDPH in March 2003. There are five divisions within IDPH structure they are: the Division of Acute Disease Prevention and Emergency Response, the Division of Behavioral Health and Processional Licensure, the Division of Environmental Health, the Division of Health Promotion and Chronic Disease Prevention, and the Division of Tobacco Use Prevention and Control.

/2008/ In January 2007, Governor Chester Culver, became Iowa's new governor. There were also many new legislators that started the session with Culver and also a democratic led House of Representatives and Senate. Iowa has not experienced this type of change in several decades. Governor Culver appointed a new Department of Public Health Director, Thomas Newton, MPP, REHS, in May of 2006. Director Newton retained the exisitng IDPH organizational structure but added a new Bureau of Communication and Planning and a Deputy Director, Mary Jones. /2008/ ***/2010/ There have been no significant changes to Iowa's organizational structure. //2010//***

Bureau of Family Health
Public health functions relating to the health of mothers, children, and families are centered in the Bureau of Family Health (BFH). Organizational structures within BFH include the Women's Health Team and the Child Health Advocacy Team. Areas of work for these teams include system planning, standards of care development, contract management, and coordination of health-related services. Both teams collaborate with the Iowa Department of Human Services (DHS), the Iowa Department of Education (IDE), and the Iowa Regents Universities. The BFH contracts with local Child Health and Maternal Health agencies and health care providers to manage MCH programs at the local level. Listings of current contractors are located in the attachment. The BFH collaborates with the Oral Health Bureau (also a branch of the Division of Health Promotion and Chronic Disease Prevention, IDPH) to issue a joint Request for Proposal (RFP). The RFP is issued to community-based organizations interested in providing public health services for MCH and Family Planning. The RFP requires contractors to link with the Bureau of Local Public Health Services, Bureau of Disease Prevention and Immunization, IDEA- Part C, Healthy Child Care Iowa, hawk-i (S-CHIP), and the Lead Poisoning Prevention Program. Selection is based on applicant's ability to meet criteria in the areas of access, management, quality, coordination, and cost.

Administration of Programs Funded by Block Grant Partnership Budget. IDPH is responsible for the administration of all programs carried out with allotments under Title V. Abstinence Education programs funded by Title V Section 510 and Special Programs of Regional and National Significance (SPRANS) are coordinated within the Bureau of Family Health (BFH). A joint project coordinator is responsible for both abstinence education budgets and is assisted by two program planners. A project director housed in the BFH administers the State Systems Development Initiative (SSDI) funds awarded to Iowa. A nurse clinician functions as a liaison between the IDPH Bureaus of Family Health and Information Management and serves as the SSDI project director. SSDI staffers works closely with the Genetics statewide coordinator who administer the grant from the MCHB Genetics Services Branch that also focuses on data integration. A project director and coordinator in the BFH administers Iowa's Early Childhood Comprehensive System project. A project coordinator in the BFH directs the administration of Iowa's Community Integrated Service Systems (CISS) grant that supports health and safety in early care and education programs. A community health consultant in the BFH serves as the coordinator for the Assuring Better Child Healthy Development (ABCD II) grant from the Commonwealth Fund. As our State Medicaid Agency, DHS was the applicant and recipient of the grant. /2008/ IDPH did not receive funds for Abstinence Education programs. IDPH did received the Perinatal Depression grant from MCHB in August of 2006. The Center for Cogenital and Inherited Disorders also received a Family Participation grant from HRSA. IDPH has also received funding from the March of Dimes to pilot the Iowa's PRAMS survey and evaluation component. /2008/ ***/2010/ Iowa expanded the newborn metabolic screening program through a HRSA grant. //2010//***

Iowa's Early Hearing Detection and Intervention Program is a collaborative effort. Child Health Specialty Clinics administers a HRSA MCH Improvement Projects Grant to improve the system of newborn hearing screening and follow-up in Iowa. In addition, IDPH is developing a surveillance and monitoring system through a cooperative agreement with the Centers for Disease Control and Prevention. In January 2004, a bill was passed by the legislature and signed by the governor

that will mandate newborn hearing screening in Iowa. The bill requires that all newborns be screened for hearing loss prior to discharge from hospital and that the results be reported to IDPH. The program director, within the BFH, has been providing technical assistance to maternity hospitals to begin data input into the eSP data system.

Early ACCESS is Iowa's program funded by the Individuals with Disabilities Education Act (IDEA, Part C). Early ACCESS is an interagency collaboration between the Iowa Department of Education, the Iowa Department of Public Health, the Iowa Department of Human Services, and Child Health Specialty Clinics. The system is a partnership between families with young children, birth to age three, and providers from local public health, human service, education, and child health specialty agencies. The Iowa Department of Education is the lead agency, as appointed by the Governor of Iowa for the implementation and maintenance of the system.

The IDPH Bureau of Family Health, in collaboration with the Community Empowerment branch of the Iowa Department of Management, applied for a HRSA State Maternal and Child Health Early Childhood Comprehensive Systems Implementation Grant in May 2005. Iowa has developed an Early Care, Health, and Education Strategic Plan and will be using the three year implementation grant to help carry out strategies. A project director in the BFH directs the coordination of the Early Childhood Comprehensive System Grant (ECCS). The grant is coordinated through the IDPH and the State Empowerment Technical Assistance Team.

ABCD II - Assuring Better Child Healthy Development
In November 2003 the National Academy for State Health Policy (NASHP) approved the Iowa Department of Human Services' grant application for the Assuring Better Child Healthy Development (ABCD) initiative. Funded by the Commonwealth Foundation, this grant project is aimed at identifying and implementing policy and system changes to support the provision of preventive care by Medicaid providers to children 0 to 3. The NASHP funding of $55,000 per year, is matched by Medicaid funding of the same amount. Iowa intends to move toward the development and infusion of healthy mental development services into our current EPSDT system. /2008/ Iowa received state funds in 2006 and 2007 General Assembly for 1st Five Healthy Mental Development. Building upon the lessons learned from the two ABCD II demonstration projects, the newly established 1st Five Healthy Mental Development Initiative seeks to develop statewide spread. Current plans include increased collaboration between 1st Five and CHSC's Iowa Medical Home Initiative (described below). /2008/ /2009/ 1st Five continued to receive state funds from the 2008 General Assembly. There are currently four local projects and an RFP has been posted to add another locality. /2009/

Responsibility for coordinating Iowa's program for CYSCHN is administered by the IDPH Division of Health Promotion and Chronic Disease Prevention through a contract with the University of Iowa, Department of Pediatrics. Within the University of Iowa, Child Health Specialty Clinics (CHSC) has responsibility for administration of the contract. A table of organization for CHSC is located in the attachment.

Child Health Specialty Clinics

/2009/ With the resignation of CHSC's physician director in December, 2007, a new program leadership structure has been developed. Leadership will be shared by a full-time Chief Administrative Officer and a part-time (0.4 FTE) Chief Medical Officer. The new leadership should be in place by the end of ffy'08. /2009/ ***/2010/ The new CHSC leadership is comprised of a single physician CHSC program director who also functions as chief medical officer. //2010//***

Responsibility for family-centered, community-based, coordinated care for children and youth with special health care needs (CYSHCN) is placed in the Child Health Specialty Clinics (CHSC) statewide system of regional child health centers. Since 1976, the regional centers have provided multidisciplinary community-based resources for children with complex health and

health-related problems. The regional centers support specialized diagnostic and evaluation services, care coordination services, family support, and infrastructure building efforts. The centers are permanently staffed by advanced registered nurse practitioners, nurse clinicians, parent consultants, and support staff. A map of the CHSC regional centers, in addition to other general program information, is located at www.uihealthcare.com/chsc.

CHSC has managed several funded grants and contracts under the general heading of the Iowa Medical Home Initiative (IMHI), which ultimately strives to meet the national goal of enrolling all CYSHCN in a medical home. A three-year MCHB grant to CHSC facilitated the establishment of medical homes for CYSHCN in self-selected pediatric and family physician practices. A companion three-year MCHB grant to the Iowa Academy of Family Physicians (IAFP) supported a more local effort to establish medical homes for young children through enhanced primary practice and public health partnerships. These grants were consolidated with the goal of boosting medical home momentum in both the pediatric and family practice provider communities. Another MCHB-funded grant, now ended, was given to CHSC to build a system of adolescent transition services to promote, among other system improvements, the medical home model for adolescents with special health care needs. A contract between CHSC and Iowa's Part C Program has provided significant professional development funds to support the IMHI effort.

As these three grants near termination, a new MCHB Integrated Community Services (ICS) grant to build integrated systems for CYSHCN will extend federal support for system improvement. This will occur through linking primary care practices to Title V care coordination resources; offering learning collaboratives to stimulate practice-based quality improvement efforts with an emphasis on chronic care improvment; and enhancing partnerships to increase early and continuous screening in primary care settings. /2007/ To date, approximately thirty primary care practices have participated in the Chronic Care Improvement Learning Collaborative. /2007/ Part C, through renewal of the professional development contract, is continuing to support this medical home-focused system improvement effort. /2008/ To meet the goal of increased collaboration with Iowa Department of Public Health's 1st Five Healthy Mental Development Initiative, the ICS grant is has begun to redirect its activity plan. The ICS grant will support a more locally intensive facilitation model with primary care practices, using early childhood developmental screening and referral as the seed for building wider medical home model practice-based quality improvements. /2008/ /2009/ A request for a no-cost extension of the ICS grant was approved by MCHB and will extend the project termination date until April 30, 2009. A new ICS project partnership will occur with the Iowa-Nebraska Primary Care Association to assist them meet a new legislative mandate. The mandate is to study how Safety Net Providers can help safety net using families determine a medical home. CHSC will offer technical assistance to safety net providers as they decide how best to adapt the medical home model to their particular service structures. /2009/

/2010/ CHSC will continue involvement in statewide spread of the medical home model by offering its care coordination expertise and service to community-based primary care providers serving CSHCN. CHSC will also lead initial development of a "family-to-family health information center," which can be another resource to emerging medical homes seeking to become more family-centered.

New ARRA-supported contracts between CHSC and Iowa's Part C early intervention program will increase CHSC's role as service coordinator for infants and toddlers enrolled in Part C. Some of the new Part C contract will also support CHSC's participation in addressing early childhood risk factors associated with selected "upstream" social determinants of health. //2010//

An attachment is included in this section.

D. Other MCH Capacity

MATERNAL AND CHILD HEALTH

The administrative office for Iowa's Title V program is located in the capitol complex in close proximity to the State Capitol, in Des Moines, Iowa. The IDPH employs the Bureau of Family Health Chief, a Division Medical Director, and 26 professional and four support staff who manage the functions of Iowa's Title V program. The department contracts with 24 local maternal health agencies and 23 local child health agencies to provide community-based MCH services throughout the state. ***/2010/ Dr. Debra Waldron serves as the IDPH Division of Health Promotion and Chronic Disease Prevention Medical Director. //2010//*** For additional information about the responsibilities and structure of the local contract agencies see section IIIB Agency Capacity.

Bureau of Family Health (BFH) staff members provide the capacity for policy development, program planning, and evaluation functions. Data reporting and analysis functions are provided through the capabilities of staff in the IDPH Bureau of Information Management (BIM) and the IDPH Center for Health Statistics (CHS). A BIM staff member serves as liaison to the BFH and focuses on data integration efforts for the major MCH data systems in Iowa. A CHS senior statistician coordinates all analysis requirements for Title V programs.

The Bureau of Family Health and the Center for Health Statistics has established an agreement with CDC to have an MCH Epidemiologist assigned to Iowa. Dr. Debbie Kane will assist the Department by providing consultation, technical assistance, surveillance and analysis of epidemiological information for Iowa's MCH population. Initial activities have focused on Needs Assessment and data integration and data linkages.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Iowa's Title V Program for CYSHCN, Child Health Specialty Clinics (CHSC), is an administrative responsibility of IDPH, Division of Health Promotion and Chronic Disease Prevention, managed through a contract with the University of Iowa, Department of Pediatrics. CHSC maintains an Iowa City administrative office, as well as 12 regional centers located in or near the state's population centers. ***/2010/ In addition to the Iowa City administrative office, there are now 13 regional centers. //2010//*** Most Iowans are within a one-hour drive of a regional center. Of the total staff complement, 18 individuals are housed in the Iowa City office. The remaining 100 staff members are housed in or associated with the other 12 CHSC regional centers. ***/2010/ The latest CHSC staff count suggests there are currently 19 staff in Iowa City and 103 staff located in the other 13 CHSC regional centers. //2010//***

The capacity to perform core public health functions is shared among professional and support staff. Policy and Planning Unit staff have education and experience in public health science and practice and take a lead role in coordinating core public health activities. Families of CYSHCN add program capacity through the Parent Consultant Network (PCN), a community-based network of part-time parent consultants affiliated with the regional centers. CHSC's family participation program is led by two experienced members of the PCN. They lead the PCN by advising on policy and program planning, recommending training, monitoring activity, and updating resource information. All parent consultants undergo a structured training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports. ***/2010/ Parent consultants are now also trained to perform specific tasks as service coordinators for selected CSHCN enrolled in Iowa's Part C Program. //2010//***

External contracts and grants have increased CHSC's capacity to contribute to prescribed priorities. Contracts with the Iowa Department of Education Part C Program expand CHSC's participation in the areas of early intervention (especially system development and quality assurance) and medical home training (especially the early childhood screening component). /2008/ A new pending contract with the Part C Program will support additional service coordination performed by CHSC parent consultants; additional nutrition consultation services for young children with developmental delay; and direct assistance to eligible families with insurance

co-pay liabilities. Specific details will be agreed to in the forthcoming contract. /2008/ ***/2010/ New ARRA-supported contracts between CHSC and Iowa's Part C early intervention program will increase CHSC's role as service coordinator for infants and toddlers enrolled in Part C. Some of the new Part C contract will also support CHSC's participation in addressing early childhood risk factors associated with selected "upstream" social determinants of health. //2010//***

A contract with the Iowa Department of Human Services commits CHSC to provide care coordination to "medically fragile " children enrolled in Medicaid Waiver Programs. A contract with Magellan Behavioral Care of Iowa supports CHSC's leadership in improving statewide access to pediatric mental and behavioral health services. /2009/ The contract with Magellan Behavioral Care of Iowa has been terminated; however, the mental and behavioral health consultation service via telehealth technology has expanded and is now funded through third-party reimbursement. /2009/ Finally, an MCHB grant supports a systems integration effort that highlights medical home model spread, linkage of primary care providers with public health care coordinators, and partnerships to improve early childhood screening and referral practices. /2007/ A new one-year contract with the Iowa Department of Public Health supports the growth of telehealth technology by researching and reporting current telehealth efforts; developing and pilot testing a training module for providers new to telehealth technology; making recommendations to enhance the effectiveness of telehealth services; and suggesting a plan to further develop and sustain telehealth. /2007/

/2007/ A bid for technical writing assistance was offered by the Iowa Department of Human Services (DHS) and won by CHSC. The product will be revised and new proposal documents suitable for submission by DHS to the Substance Abuse and Mental Health Services Administration (SAMHSA) for funds to support a major children's mental health systems improvement effort. /2007/ /2008/ The proposal to SAMHSA was successful and CHSC is now contracted to lead the clinical care component of a major system improvement effort in ten counties of NE Iowa for children with severe emotional disorders. This six year effort is intended to produce a sustainable model that can successfully spread to the entire state. /2008/

Another significant element of program capacity relates to service billing. CHSC professional services are systematically billed at levels that accurately reflect the intensity and skill of the service. A sliding fee scale continues to be employed to determine family liability.

Senior level management employees are M. Jane Borst, chief of the IDPH Bureau of Family Health and Dr. Jeffrey Lobas, director of Child Health Specialty Clinics. Their qualifications appear in brief biographies attached to this section. /2009/ Dr. Lobas resigned in December 2007. A new CHSC program leadership structure has been developed. Leadership will be shared by a full-time Chief Administrative Officer and a part-time (0.4 FTE) Chief Medical Officer. The new leadership should be in place by the end of ffy'08. /2009/ ***/2010/ The new and sole CHSC program director is Debra Waldron, MD, MPH, board-certified pediatrician. Dr. Waldron also serves as the medical director for the Iowa Department of Public Health's Division of Health Promotion and Chronic Disease Prevention. //2010//***

An attachment is included in this section.

E. State Agency Coordination

The following descriptions highlight significant organizational relationships within Iowa that enhance the capacity of the Title V program. These descriptions do not capture extensive coordination efforts undertaken by the state's Title V program. A complete listing of formal and informal organizational relationships is located in the attachment.

Special Supplementary Nutrition Program for WIC
The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) coordinates

with MCH services at the local level to provide a comprehensive service delivery model for low-income families. The Bureau of Nutrition and Health Promotion coordinates the nutrition components of MCH projects and provides staff assistance. Training, consultation, and educational programs are provided for all MCH programs. The Iowa Lactation Task Force, a statewide coalition, includes private sector and public health professionals who provide technical assistance to the WIC program, MCH, family planning, public health agencies, and primary care providers.

/2007/ WIC's short-term intervention program, coupled with the services provided by MCH, is designed to strengthen families by influencing lifetime nutrition and health behaviors in a targeted, high-risk population. WIC's combination of nutrition education, nutritious foods, breastfeeding support and referrals to MCH services provides a gateway to good health in more than 140 clinics administered by 20 local agencies. /2007/

Family Planning
IDPH provides family planning services in 45 of the 99 counties in Iowa. A program coordinator, housed in the IDPH Bureau of Family Health, manages services provided by eight contracted agencies. IDPH Family Planning Service Area (IDPH/FPSA) includes four metropolitan counties and two urban counties. The balance of the IDPH/FPSA contains rural counties. The Iowa counties not part of the IDPH/FPSA are funded through the Family Planning Council of Iowa.

/2007/ In January 2006, the Center for Medicare and Medicaid approved Iowa's request to waive section 1115 of the Medicaid rules in order to implement a demonstration program that expands the eligibility for Medicaid covered family planning services in Iowa. The program, called the Iowa Family Planning Network (IFPN), expands eligibility for Medicaid covered family planning services to all Medicaid covered post partum women for one year without eligibility redetermination. It also expands eligibility for the program to all Iowa women aged 12 through 44 years, whose income is up to 200 percent of poverty. Iowa women can take required documentation to family planning clinics and receive services immediately. IDPH anticipates that IFPN will provide expanded access to free family planning services and potentially decrease the number of unintended pregnancies in Iowa. /2007/

/2008/ In February 2006 Iowa implemented the Iowa Family Planning Network (FPN). IFPN is Iowa's program developed to implement it's waive of section 1115 of the Medicaid rules. Title X family planning clinics have to enter client information onto a secure Medicaid web site for determining eligibility for the program at the family planning clinic site. From February 1 to December 31, 200 approximately 25,000 females have been enrolled into IFPN. The IFPN program reimburses the Title X contract agencies for services that previously were not reimbursed or for which the family planning agencies received minimal reimbursement. Evaluation of IFPN began in January 2007. IDPH anticipates the IFPN evaluation will show a decrease the unintended pregnancies in Iowa and a savings of Iowa and federal Medicaid expenditures. IDPH /2008/

/2009/ The IDPH Family Planning Program works closely with Family Planning Council of Iowa, the other Title X grantee in Iowa to create efficiencies in carrying out required functions. Examples include participating in the joint Training and Education Advisory Committee and planning for the annual family planning conference. IDPH works closely with Iowa Department of Human Services in carrying out the 1115 Medicaid Waiver program - IFPN. IDPH also participates with The Iowa Initiative to Reduce Unintended Pregnancies, a statewide project to reduce unintended pregnancies in Iowa in women 18-30 years. The Iowa Initiative is a multi-year effort that is working with the University of Northern Iowa (UNI). The Title X delegate agencies will be cooperating with the Iowa Initiative and UNI as appropriate. There may be opportunities to participate in research projects. /2009/

/2010/ IDPH works closely with Iowa Department of Human Services in carrying out the 1115 Medicaid Waiver program, or IFPN. Title X family planning clinics may register IFPN

clients on site through secure Medicaid Web site. From February 1, 2006 to December 31, 2008, approximately 54,934 females were enrolled into the IFPN program. IDPH anticipates that IFPN will continue to provide expanded access to no-cost family planning services and potentially decrease the number of unintended pregnancies in Iowa. Evaluation of IFPN began in January 2007. IDPH anticipates the IFPN evaluation will show a savings of Iowa and federal Medicaid expenditures. The IDPH Family Planning Program works closely with Family Planning Council of Iowa to create efficiencies in carrying out required functions. IDPH participates with the Iowa Initiative to Reduce Unintended Pregnancies, a statewide project to reduce unintended pregnancies in Iowa in women ages 18 to 30. The Iowa Initiative is a multi-year, foundation-supported effort that is working with the University of Northern Iowa (UNI). In 2008, legislators passed legislation and appropriation for the development of the State Funded Family Planning (SFFP) program. In February, 2009, agencies began billing for SFFP services. Women who are not eligible for IFPN because of age, insurance coverage (that does not cover family planning services) or who are citizens but cannot document citizenship may qualify for SFFP program services. //2010//

DHS Cooperative Agreement
IDPH, Division of Health Promotion and Chronic Disease Prevention maintains an ongoing cooperative agreement with DHS. The agreement defines cooperative efforts toward an integrated system of high quality, comprehensive, cost-effective, adequately financed health services for mutual beneficiaries. The annual agreement is available upon request.

EPSDT Care for Kids
The IDPH provides services for the EPSDT Care for Kids program under an intergovernmental agreement with DHS. Under this agreement, local CH contract agencies are approved as EPSDT screening centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the about the child's Medicaid coverage and the importance of well-child care. Care coordinators also contact the family when the child is due for well-child care according to the EPSDT Periodicity Schedule. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical and dental care. Care coordinators partner with local physicians to ensure that children receive the comprehensive screening requirements of the program. BFH staff provide training and technical assistance to EPSDT care coordinators. Topics include developing care coordination skills, determining the costs for informing and care coordination activities and maintaining the electronic clinical record.

State agency coordination is necessary throughout the EPSDT Care for Kids program in order to assure that families receive appropriate services. Data system integration between the two state departments occurs every day in order to give local CH agencies access to current Medicaid eligibility information. To accomplish this level of integration the Iowa Title XIX database at DHS sends eligibility information to the Child and Adolescent Reporting System (CAReS) at IDPH every day. The next day local CH agencies can obtain Medicaid eligibility information for a child directly from CAReS. As services are provided to the child, clinical record documentation is entered in CAReS. The BFH coordinates with related IDPH programs in managing the EPSDT Care for Kids program. Ongoing and routine communication occurs with program staff involved in immunizations, lead poisoning prevention, early intervention services, oral health, behavioral health and other programs related to the health of Iowa's children.

/2009/ Due to the release of the federal Targeted Case Management Interim Final Regulation, the BFH and DHS (Iowa Medicaid Enterprise) have been developing plans regarding the future delivery of informing and care coordination services under the EPSDT program. Both agencies recognize the extensive case management requirements within the regulation are not appropriate for population-based preventive health services. As a result, the Iowa Medicaid Enterprise has proposed removing informing and care coordination from the Medicaid State Plan as Targeted Case Management Services and classifying them as ‘administrative services'. DHS would then

contract with IDPH to reimburse informing and care coordination services to local contract agencies. Contract language has been drafted and submitted to the Centers for Medicare and Medicaid Services along with proposed Medicaid State Plan changes. Local contract agencies have been apprised of the proposed plans through meetings, conference calls and the FFY 2009 Request for Application. /2009/

/2010/ Upon execution of the agreement between BFH and DHS (Iowa Medicaid Enterprise), IDPH began paying fee-for-service claims for EPSDT informing and care coordination services provided by local contract agencies for services provided as of February 2, 2009. Per the agreement, these services are classified as 'Medicaid administrative' services. Program development included creation of billing procedures and forms, parameters for BFH quality assurance review of claims, enhancements to the Child and Adolescent Reporting System (CAReS), and a variety of training opportunities for local contract agencies. Local contract agencies continue to provide gap filling direct care services based upon local need. Assurance of medical and dental homes for regular preventive health care for children remains a cornerstone of the work accomplished by contractors. Continued emphasis is placed on quality assurance and quality improvement pertaining to documentation and delivery of services. Each local agency conducts regular internal review of service documentation in CAReS with quarterly reporting of results. //2010//

hawk-i (Healthy and Well Kids in Iowa)
In October 2002, DHS contracted with IDPH to provide grassroots outreach and enrollment for hawk-i. In November 2002, IDPH contracted with the 24 local CH agencies to perform hawk-i outreach and enrollment efforts. Collaboration between IDPH and DHS will continue to guide successful outreach to uninsured families in Iowa. Outreach efforts focus on four areas: schools, health care providers, faith-based organizations and special populations. Additional efforts have included businesses, workforce development, chambers of commerce, insurance agents, tax preparation sites and many other areas.

/2007/ IDPH continued to contract with DHS to provide hawk-i outreach efforts through the 24 local child health agencies. The Outreach Task Force meetings take place twice a year at two statewide conferences and are being supplemented with regional meetings that encourage networking among coordinators. Training for new coordinators are offered through task force meetings. Coordinators are also required to attend certain breakouts at the two statewide conferences. /2007/

/2008/ IDPH renewed their contract with DHS to provide hawk-i outreach through the local child health agencies. The Outreach Task Force meetings continue to take place twice a year at two statewide conferences. The statewide outreach coordinator made site visits to local agencies to provide technical assistance and offer one-on-one training to new coordinators. Trainings on cultural competence were offered to coordinators through Web casts. Outreach continues to focus on the original four target areas: schools, health care providers, faith-based organizations and special populations. An emphasis was also placed on collaborating with Community Health Centers. /2008/

/2009/ IDPH continued to contract with DHS to provide hawk-i outreach through the local child health agencies. Outreach to Community Health Centers has been taken to a new step and in Iowa's largest urban setting of Des Moines, a local coordinator spends part of her week in the clinics enrolling families. The coordinator is also working on a best practices toolkit working with CHCs that can be shared with other Title V agencies. A large emphasis is still being placed on conducting outreach to underserved populations in Iowa through various means such as local businesses that either employ or serve large numbers of underserved populations, service providers and local festivals. Outreach was also conducted on a statewide level at tax preparation sites for those qualifying for the earned income tax credit and Pay day loan and check cashing facilities. /2009/

/2010/ IDPH continued to contract with DHS to provide hawk-i outreach through the local CH agencies. Local outreach coordinators are required to submit action plans focusing efforts on faith-based, schools, medical providers and vulnerable populations, and coordinators continue to expand beyond the four required areas. Local coordinators share their best practices at Outreach Taskforce meetings. Emphasis is placed on reaching out to vulnerable populations (e.g. attending health summits and assisting in planning statewide events focusing on the health of vulnerable populations). The state coordinator works with the farming community to conduct outreach including outreach through the Iowa Farm Bureau and displays at the Midwest Farm Progress Show. //2010//

Preventable Diseases Program
The Disease Prevention and Immunization Bureau administers the program for vaccine preventable diseases. Vaccines are available to local health departments, child health agencies and private physician's offices for required childhood immunizations. The Immunization Registry Information System (IRIS), a web-based registry, now serves the state's public sector clinics and private providers. The Bureaus of Family Health and Disease Prevention and Immunization and DHS collaborate to promote statewide utilization of the registry in both public and private clinics.

Childhood Lead Poisoning Prevention Program
Since nearly 40 percent of the state's housing was built prior to 1950, the IDPH recommends that all Iowa children under the age of six receive routine blood lead testing. Local contract agencies, local health departments and private practitioners test children. IDPH educates private practitioners about the importance of testing children for lead poisoning. Case management of children with lead poisoning is a collaborative effort of the Childhood Lead Poisoning Prevention Program, the Bureau of Family Health, local contract agencies and local health departments.

Bureau of Local Public Health Services
The bureau was established to strengthen the public health delivery system in Iowa at both the state and local level. This will be achieved through strengthening the capacity of Iowa's local boards of health that, through local health departments, public health agencies, programs and services, strive to create healthy people in Iowa communities.

The bureau promotes and supports development of public health infrastructure at the local and state level to assure that Iowa's public health system has the capacity to be responsive to current and emerging public health issues. /2009/ Bureau staff have been providing training and technical assistance to local public health agencies on Iowa's public health standards. /2009/

/2010/ The Bureau of Local Public Health Services provides technical assistance and consultation to local boards of health and local public health departments in preparation for meeting the Iowa Public Health Standards developed through Public Health Modernization. Development of the public health infrastructure at the local and state level helps assure that Iowa's public health system has the capacity to be responsive to current and emerging public health issues. //2010//

Iowa Center for Congenital and Inherited Disorders
The Center for Congenital and Inherited Disorders (CCID), in partnership with the University of Iowa and health care providers throughout the state, provides comprehensive genetics services. IDPH manages the five CCID programs with assistance from the Congenital and Inherited Disorders Advisory Committee (CIDAC). The five programs are the Iowa Neonatal Metabolic Screening Program (INMSP), the Expanded Maternal Serum Alpha-fetoprotein Screening Program (MSAFP), Regional Genetic Consultation Services (RGCS), the Neuromuscular and Related Disorders Program, and the Iowa Registry for Congenital and Inherited Disorders (IRCID). The INMSP, the RGCS, and the Neuromuscular and Related Genetic Disorders Program conduct statewide outreach clinics. Clinics offer diagnostic evaluation, confirmatory testing, medical management, education, case management, consultation and referral.

The IRCID mission is to maintain statewide surveillance for collecting information on birth defect occurrence in Iowa, monitor annual trends in birth defect occurrence and mortality, conduct research studies to identify genetic and environmental risk factors for birth defects and promote educational activities for the prevention of birth defects. In 2002, the IBDR developed a parental notification system that informs parents or guardians of children who are diagnosed with a birth defect and provide them with resource information. The parental notification system includes a resource brochure and a notification letter. IDPH also works with the various early intervention programs including Early ACCESS, local MCH agencies, IDPH Child Health Advocacy Team, and parent groups to ensure that IRCID data are made available for program planning. The CCID works closely with the Early Hearing Detection Initiative to coordinate screenings for all newborns in the state.

Matching newborn metabolic screening and birth certificate records is performed to identify unscreened newborns. Follow-up occurs with the birthing facility and/or physician's office to arrange for screening of missed newborns. The INMSP and IBDR collaborate with the Child Death Review Team to decrease unnecessary contact of families whose child has died. Newborn screening education to nursery managers, lab managers, and health care providers is provided through the quarterly Heel Stick News and the INMSP Healthcare Practitioner's Manual found on the Web site.

The IRCID will begin conducting surveillance on stillbirths starting in October 2005. Birthing facilities will receive education from the Statewide Perinatal Care Team on the use of a stillbirth evaluation tool. Providers will complete the information required in the tool, and submit it to the IRCID.

/2007/ The CCID has added two additional programs: the Iowa Stillbirth Surveillance Project (ISSP) with coordinating prevention activities and the Family Health History Initiative. The ISSP expands on the existing birth defects registry to include surveillance of fetal deaths in Iowa. This surveillance is conducted through a cooperative agreement with the CDC. Through education sessions and promotional materials, the Family Health History Initiative was introduced and disseminated. /2007/

/2008/ The CCID received a grant, Iowa's Family Participation Project, from HRSA for $100,000 for three years. The grant will address: attitudes and beliefs of parents, family and provider participation, implementation and evaluation, and improving education information for parents and providers. Through the 2007 General Assembly CCID will convene a task force on postnatal tissue and fluid banking. /2008/

/2009/ In 2007, South Dakota became the latest state to contract with the Iowa newborn screening program to conduct its statewide testing. Louisiana has resumed testing for its newborns, expanding its testing panel with the assistance of the Iowa program. /2009/

/2010/ In 2008, the INMSP welcomed North Dakota to the program. Iowa conducts the testing of specimens from ND, and ND conducts its own follow-up. Iowa continues to provide testing and follow-up for South Dakota and Iowa. Testing is conducted for four countries in the Middle East, and the medical director continues to provide consultation to Louisiana. The statewide courier service and the addition of laboratory night shift testing implemented in 2006 has resulted in improved reporting times of abnormal screening results. The average reporting time has decreased from three days after collection, to one and one-half days. The CCID has partnered with efforts of Healthy Birth Day, a local non-profit organization that aims to raise awareness and prevention of stillbirths. This organization developed the "Count-the-Kicks" initiative, to inform pregnant women and health care providers about the importance of monitoring fetal activity as an indicator of wellbeing. Efforts are underway to explore the integration of the EHDI data system with the INMS data system. //2010//

Unintentional Injury Prevention
The BFH collaborates with multiple partners to prevent unintentional injuries to children. Staff from the BFH provide leadership on the Iowa Safe Kids Coalition as well as the Greater Des Moines Safe Kids Coalition. Through the Healthy Child Care Iowa campaign, state agencies collaborate regarding health and safety in child care. Distance learning opportunities are offered quarterly to consultants who work with early care and education.

The BFH works closely with the Governor's Traffic Safety Bureau (GTSB) to identify strategies for information dissemination. Local MCH agencies are able to request free educational materials from the GTSB to share with clients, particularly regarding child passenger safety.

The BFH collaborates with the Division of Environmental Health's liaison to the U.S. Consumer Product Safety Commission. Child care nurse consultants visit child care and early education providers on-site using a Consumer Product Safety Commission-approved checklist to assess hazardous and recalled children's products.

Early ACCESS
Early ACCESS is a federal program under the Individuals with Disabilities Education Act (IDEA, Part C). In Iowa, the program is an interagency collaboration among the Departments of Education, Public Health, Human Services, and CHSC. The system is a partnership between families with young children, ages 0 to 3, and providers from local public health, human service, education and Child Health Specialty Clinics. The Iowa Department of Education (DE) is the lead agency, as appointed by the Governor for the implementation and maintenance of the system. A state level multidisciplinary council, the Council for Early ACCESS advises and assists the DE in the implementation of Early ACCESS.

/2007/ Signatory partners continue to collaborate with the DE to address the needs of children ages 0-3 with developmental delays or the risk of delay and their families. State staff is working to incorporate IDEA 2004 Law changes that impact Part C into Iowa practice. Early ACCESS is concentrating efforts to standardize practice across service delivery areas. Service coordinator training on competencies has been developed. /2007/
/2009/ A State wide procedure manual has been drafted to facilitate the standardization process. Service coordinator training around competencies has been developed and work is being done to increase the constancy in the tools used to evaluate and monitor children's development. /2009/

/2010/ Training on the state wide procedure manual to facilitate standardization for service coordination has rolled out. An application for a Web based IFSP will be tested and rolled out for full implementation. Training has been provided to increase the consistency among tools used to screen, evaluate and monitor children's development. Early ACCESS provides leadership for implementing developmental screening. A statewide train-the-trainer project for the ASQ and ASQ-SE is in progress. //2010//

Federally Qualified Health Centers
/2010/ Iowa currently has 14 FQHCs: Community Health Care in Davenport, Community Health Center of Fort Dodge, Community Health Centers of Southeastern Iowa in West Burlington, Community Health Centers of Southern Iowa in Leon and Lamoni, Council Bluffs Community Health Center, Crescent Community Health Center in Dubuque, Des Moines Health Center in Des Moines, Greater Sioux Community Health Center in Sioux Center, Linn Community Care in Cedar Rapids, Peoples Community Health Clinic in Waterloo, Primary Health Care in Des Moines, River Hills Community Health Center in Ottumwa, Siouxland Community Health Center in Sioux City and United Community Health Center in Storm Lake. //2010// Storm Lake and Fort Dodge received New Start Funds in December 2005 with operations to begin in April 2006. Two of the centers have subcontracts with IDPH for local CH contract agencies. The remaining FQHCs collaborate with the designated MCH agencies in their area.

Primary Care Association
The IDPH has a long-standing relationship with the Iowa/Nebraska Primary Care Association (IA/NEPCA). The Association provides technical and non-financial assistance to the community and migrant health centers of Iowa and Nebraska. These health centers offer comprehensive, physician-based "one-stop" primary care with a focus on prevention. The seven community health centers in Iowa are IA/NEPCA members. The Association works closely with the state departments of health in Iowa and Nebraska, along with the Federal Bureau of Primary Health Care, and participates in collaborative activities promoting quality health care services.

College of Public Health, The University of Iowa
The College of Public Health strives to be a comprehensive public health resource for the state of Iowa. There are six departmental units: Biostatistics, Community and Behavioral Health, Epidemiology, Health Management and Policy, Occupational and Environmental Health, and the Program in Public Health Genetics. Degree programs include the MPH, MS, MHA, and PhD. A Public Health Certificate Program was initiated in 2002.

Des Moines University
The Master of Public Health program at Des Moines University (DMU) began in 1999 and received full accreditation from the Council on Education for Public Health in 2002. A dual degree program offers students the opportunity to obtain both the MPH and MPA. A Graduate Certificate in Public Health is also offered.

Child Health Specialty Clinics
The Child Health Specialty Clinics (CHSC) administrative offices are located at the University of Iowa in Iowa City. Proximity to a major university health center provides a source of pediatric and public health expertise that is shared with CHSC's statewide staff and collaborating agencies. Continuing education programming occurs on-site in Iowa City, at community locations, over the statewide fiberoptic communication network, and via internet webcam connections. Health professions and public health students - graduate and undergraduate - learn about community-based service delivery through participation in direct care specialty clinics, care coordination services, and infrastructure building activities. CHSC's relationship with the University provides information technology resources, financial management services, public policy expertise, and research design and program evaluation consultation.

CHSC maintains interagency agreements with state entities. The following list indicates the agencies with which CHSC maintains agreements and summarizes the purpose of each agreement. CHSC has formal agreements with:

1) IDPH, BFH - to promote development of a cooperative and collaborative relationship at state and local levels through cross-referrals, sharing of staff, coordinating staff training, and interfacing data systems;
2) IDPH, BFH - to provide public health services at the community level including Child Health, Child Dental Health, and hawk-i Outreach;
3) DE, Division of Vocational Rehabilitation, Disability Determination Services Bureau - to define responsibilities related to applicants and recipients under age 16 of the Supplemental Security Income (SSI) Program and under age 22 who need specialized health services regardless of SSI eligibility; /2009/ (This agreement is no longer in effect due to the Social Security Administration's need to review procedures for the purpose of assuring SSI client confidentiality. CHSC hopes to renew the agreement as soon as possible.) /2009/ ***/2010/ Recent correspondence suggests this agreement will be reinstituted in late '09 or '10. //2010//***
4) Area Education Agencies - to provide service coordination, as defined in Iowa's IDEA rules and regulations, through a family-centered process to infants and toddles and their families when eligibility is based on a health or medical condition;
5) IDHS - to define responsibilities of the parties in assessment, planning, and care coordination activities for children with special health care needs who are recipients of the EPSDT Program of Title XIX (Iowa Medical Assistance Program);

6) IDHS - to define responsibilities of the parties in assessment, planning, and care coordination activities for applicants and recipients of the consolidated Waiver Programs of Title XIX;
7) IDHS (through its contract with Magellan Health Services for the Iowa Plan for Behavioral Health Medicaid Community Reinvestment Funding) - to develop a statewide system to deliver comprehensive child psychiatric services to Iowa Plan Medicaid enrollees ages 0-21 with mental health needs living in rural or underserved areas and to improve the skills of community-based providers serving the target population. /2009/ The CHSC component of the Magellan contract has been terminated, though CHSC's child psychiatric consultation services have expanded and are now supported by third-party reimbursement. /2009/
8) IDPH, IDOE, and IDHS - to delineate roles and responsibilities in the implementation of Part C of IDEA, including coordination and nonduplication of services.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	48.4	48.4	42.7	42.9	28.1
Numerator	875	875	820	841	565
Denominator	180755	180755	192055	195916	201321
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The 2008 data were obtained from the Iowa Hospital Association.

Notes - 2007
The 2007 data were obtained from the Iowa Hospital Association.

Notes - 2006
The 2006 data were obtained from the Iowa Hospital Association.

Narrative:
Iowa's Asthma Control Program continues to be guided by the Iowa Plan for Improving the Health of Iowans with Asthma, adopted in 2003. At its April 26, 2007 meeting, the Iowa Asthma Coalition adopted a Strategic Plan for Improving Asthma Treatment and Self-Management through Systems Level Interventions (2007-2010). The strategic plan contains input from the education, environment, and surveillance subcommittees of the statewide coalition. Each goal of the strategic plan is supported by specific action steps and measurement indicators.

The report for HSCI #01 appears on Form 17.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	99.9	94.6	95.5	88.3	87.9
Numerator	17565	17636	18498	17841	17575
Denominator	17590	18639	19379	20200	20001
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

2008 Data were obtained from the CMS 4.16 Annual EPSDT Participation Report. Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.
Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Narrative:

/2010/ Iowa's Title V program contracts with 23 local community-based agencies for the Child Health program covering each of Iowa's 99 counties. A primary focus of the child health program is to assure that children served receive the well child screening services that they are eligible for according to guidelines established in the Iowa Recommendations for Scheduling Care for Kids Screenings (EPSDT Periodicity Schedule). Local contract agencies provide care coordination services to link children to medical homes for the well child screening services. Based upon a local needs assessment, child health contractors may provide selected gap-filling direct care services, and a few continue to provide the full well child screen.

The Bureau of Family Health has established an intergovernmental agreement with the Iowa Department of Human Services. Under this agreement, local child health contract agencies are approved as Medicaid Screening Centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the child's Medicaid coverage and the importance of well child services. Care coordinators also contact the family when the child is due for well child screens according to the Iowa Recommendations for Scheduling Care for Kids Screenings. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical care. Care coordinators are encouraged to partner with local physicians to ensure that children receive their regular well child exams. //2010//

The report for HSCI #02 appears on Form 17.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	6	15	9	9	8
Denominator	6	15	9	9	8
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 Data were obtained from hawk-i data.

Notes - 2007
Data were obtained from hawk-i 2007 data. The small number is due to financial eligibility at 185 percent poverty level. Most infants who qualify for public health insurance qualify for Medicaid.

Notes - 2006
The small number is due to financial eligibility at 185 percent poverty level. Most infants who qualify for public health insurance qualify for Medicaid.

Narrative:
/2010/ During 2008, the income eligibility guidelines for both Medicaid and hawk-i were 200% of FPL for infants 0 to 1. Iowa's hawk-i program did allow for a 20% disregard for earned income that Medicaid did not. Only a very small number of infants were enrolled in hawk-i due to Federal CHIP policies requiring that any child who applies for hawk-i but is eligible for Medicaid, be enrolled in Medicaid. During the 2008 legislative session, SF 389 was passed and signed by the Governor which effectively raised eligibility to 300% for infants in both Medicaid and hawk-i starting July 1, 2009. Infants should no longer be enrolled in hawk-i because the 20% disregard will not applied to this new eligible population which should eliminate the small discrepancy between the two programs income eligibility requirements for infants. //2010//

The report for HSCI #03 appears on Form 17.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	76.2	75.2	82.8	74.0	74.4
Numerator	29096	29336	32539	29602	29431
Denominator	38159	39014	39275	40000	39573
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data were obtained from 2008 Vital Statistics data.

Notes - 2007
Iowa implemented a revised birth certificate during this reporting period. The questions about entry into prenatal care was changed. Data staff are investigating the accuracy of the reporting. Data were obtained from 2007 Vital Statistics data.

Notes - 2006
An error in our calculations of the previous years Kotelchuek index was identified. This was corrected for this year and future years.

Narrative:
/2010/ Direct health care, enabling, and population-based program activities are provided by 24 local maternal health grantee agencies serving all 99 counties in Iowa. Maternal health grantee agencies provide services to facilitate early entry into prenatal care. These services include Medicaid presumptive eligibility determination, care coordination, case management including follow-up, and case-finding and outreach with a focus on high-risk women. The IDPH works with the Iowa Department of Human Services (DHS) to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

Local MH contract agencies continue to use the Women's Health Information System (WHIS) to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. IDPH is opening up the WHIS data system for an upgrade to incorporate the updated Medicaid Risk Assessment from the Iowa Department of Human Services. The WHIS upgrade will also add service documentation features to comply with recently revised Medicaid documentation requirements. //2010//

The report for HSCI #04 appears on Form 17.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	61.7	63.6	64.9	44.1	45.0
Numerator	141222	151992	159473	109659	114749
Denominator	228738	239068	245785	248599	255061
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.
Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Notes - 2006
The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report. The numerator represents the number of Medicaid eligible individuals who received at least one initial or periodical screen. The denominator represents the number of individuals eligible for EPSDT.

Narrative:
/2010/ As previously noted in HSCI #2, Iowa's Title V program contracts with 23 local agencies for the Child Health program covering each of Iowa's 99 counties. A primary focus of the child health program is to assure that children served receive the well child screening services that they are eligible for according to guidelines established in the Iowa Recommendations for Scheduling Care for Kids Screenings (EPSDT Periodicity Schedule). Local contract agencies provide care coordination services to link children to medical homes for the well child screening services. Based upon a local needs assessment, child health contractors may provide selected gap-filling direct care services, and a few continue to provide the full well child screen.

The Bureau of Family Health has established an intergovernmental agreement with the Iowa Department of Human Services. Under this agreement, local child health contract agencies are approved as Medicaid Screening Centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the child's Medicaid coverage and the importance of well child services. Care coordinators also contact the family when the child is due for well child screens according to the Iowa Recommendations for Scheduling Care for Kids Screenings. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical care. Care coordinators are encouraged to partner with local physicians to ensure that children receive their regular well child exams. //2010//

The report for HSCI #07A appears on Form 17.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	51.9	52.8	53.7	54.3	55.5

Numerator	22678	24390	25768	26494	27647
Denominator	43717	46216	47985	48795	49855
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2008 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2006
The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Narrative:
The I-Smile Program was developed to fulfill a legislative directive to assure a dental home for Medicaid-enrolled children. The program emphasizes early intervention, prevention, and family-centered assistance. Primary strategies of the I-Smile Program were implemented in the Title V grantee agencies throughout Iowa and fully integrated with the local EPSDT programs. The IDPH dental director works with Community Health Center dental providers, emphasizing integrating their services within local public health and involvement in community-based health planning.

The IDPH Oral Health Bureau provides contracted funding to seven local child health agencies for the provision of school-based dental sealant programs during FFY08. The programs provide dental screenings and/or examinations and dental sealants to low-income, uninsured, and/or underinsured children in school-based settings. EPSDT care coordinators work with children identified with untreated decay or no source of regular dental care to assist them in accessing follow-up care from local dentists.

The report on HSCI #07B appears on Form 17.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	92.4	91.9	91.7	0.0	0.0
Numerator	1201	1175	1058	0	0
Denominator	1300	1278	1154	1150	1150
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The Social Security Administration's (SSA) information disclosure rules and regulations continue to be under review during this reporting year. Therefore, CHSC continues to NOT receive information regarding SSI-enrollees in Iowa. In June 2009, CHSC received notice from the SSA regarding readiness to negotiate a new memorandum of agreement (or data exchange permit) to share SSI enrollment information. We expect discussions to resume later in ffy'09 or early ffy'10 resulting in a new information sharing agreement.

The denominator value is a rough estimate based on prior years when SSA shared beneficiary information.

Notes - 2007
The Iowa Title V CSHCN Program is unable to supply data for HSCI #8 because of an SSA-initiated interruption in the sharing of data regarding children < 16 years old enrolled in the SSI Program. There are apparently confidentiality-related questions that have remained unresolved since early calendar year 2007. If and when sharing of SSI enrollement data with CHSC resumes, CHSC will, in turn, resume contacting families of SSI-enrolled children to offer assistance connecting children and families to needed rehabilitative services.

Denominator value is a rough estimate based on prior years when SSA shared beneficiary information.

Notes - 2006
Our Iowa Title V definition of rehabilitative services includes mailing a detailed letter to each family of a child determined eligible for SSI. The letter reiterates the beneficiary's eligibility and encourages application for Medicaid, as well as describes additional Title V CYSHCN services that may be useful or of interest.

The Title V CYSHCN Program realizes that receiving a letter inviting SSI beneficiary families to request assistance from Title V is not precisely the same as providing "rehabilitative services." We do, however, believe that the letter does offer a potential connection between SSI beneficiary families and Title V services.

Narrative:
Child Health Specialty Clinics continues to distribute information letters to over 90% of families whose children are approved for SSI Program enrollment. The reason that 100% of families don't receive an information letter is because a relatively small percentage of SSI-approved children reside in foster homes or other out-of-home placements and are in regular and close contact with Iowa's Department of Human Services (DHS). For those children, DHS is the logical and more effective resource regarding rehabilitative services. For the large majority of SSI-approved children that are not in foster care or other out-of-home placement, CHSC offers a reminder for families to apply for Medicaid services. Medicaid eligibility is automatic, but enrollment is not, so application is necessary. The CHSC letter also provides other information regarding access to direct health care services, care coordination, and financing. Families are encouraged to contact the CHSC regional office nearest them if they feel CHSC might be of assistance. This would then begin a more formal service relationship between the SSI-approved child, their family, and the State Title V CYSHCN Program.

In FFY07, problems with interagency sharing of SSI Program enrollment data has prevented CHSC from distributing information letters to families. Negotiations between CHSC, the Disabilities Determination Services Bureau, and the Social Security Administration are in progress to review and reaffirm a memorandum of agreement to permit interagency sharing.

/2010/ The Social Security Administration's (SSA) information disclosure rules and regulations continue to be under review at the time of this Application submission.

However, CHSC recently received notice from the SSA regarding readiness to negotiate a new memorandum of agreement (or data exchange permit) to share SSI enrollment information with CHSC. We expect discussions to resume later in FFY09 or early FFY10 resulting in a new information sharing agreement. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	7.9	5.9	6.8

Narrative:
/2010/The Medicaid claims file/birth certificate linked file for calendar year (CY) 2007 was used to calculate the percent of Iowa infants born with LBW. The proportion of LBW infants born to Iowa mothers overall (2005 =7.1; 2006=6.7; 2007=6.8), those born to Medicaid recipients, (2005=8.7; 2006=8.2; 2007=7.9) and those born to non-Medicaid recipients (2005=6.3; 2006=5.8;2007=5.9) have changed little in the years 2005 through 2007. The IDPH will address this stable trend in LBW by using new data sources to provide a clearer understanding of appropriate intervention strategies. With support from the March of Dimes, IDPH conducted an Iowa-PRAMS pilot and in FFY07 and 08. Data analysis is progressing as planned.

In response to the high proportion of Medicaid women who reported that they smoked during pregnancy, beginning in January 2008, Medicaid implemented coverage for a smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits. Strategies are being implemented to increase recipients' knowledge and awareness of the smoking "Quit-line". Evaluation of the effectiveness of the new Medicaid benefit is planned beginning with the 2007 birth cohort. //2010//

The report for HSCI #05A appears on Form 15.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	5.5	5.3	5.4

Narrative:

/2010/ The Medicaid claims file/birth certificate linked file for calendar year (CY) 07 was used to calculate the Infant Mortality Rate (IMR) for Iowa infants. The overall IMR increased slightly (2005= 5.0; 2006=5.2; 2007=5.4). The IMR for non-Medicaid infants increased from 2006=4.3 to 2007=5.4. This increase needs to be assessed to determine if the difference is statistically different from year 2006 to 2007.

The IMR for Medicaid infants increased from 2006=4.3 to 2007=5.5. The IDPH will monitor this finding closely to determine whether the increase is sustained.
The IDPH will use new data sources to enhance understanding of appropriate intervention strategies. Further IPRAMS analysis and the future project PPOR planned for FFY 09-10 will assist Iowa's maternal health system to use evidence-based practices to identify gaps in community resources and define disparities. //2010//

The report for HSCI #05B appears on Form 18.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	60.6	78.9	71

Notes - 2010
The data for percent of infants born to pregnant women receiving prenatal care beginning in the first trimester were obtained from 2007 data, not 2008 data which is in the NPM data source

Narrative:
/2010/The Medicaid claims file/birth certificate linked file for calendar year (CY) 07 was used to examine the proportion of women who initiated prenatal care (PNC) in the first trimester. The overall proportion of Iowa mothers who initiated PNC in their first trimester decreased by 15 percent for CY07 compared to CY06. We do not believe that this decrease is a true reflection of PNC initiation by Iowa women during pregnancy. Rather, like other states that have begun to use the 2003 revision of the birth certificate and have used these data to calculate PNC initiation, have noted a less than expected result based on a new calculation. Likewise the proportion of non-Medicaid mothers who initiated PNC in the first trimester in CY07 decreased by about 15 percent compared to CY06. A similar result for PNC initiation is also noted for Medicaid mothers. At the same time the gap between PNC in the first trimester by Medicaid moms compared to non-Medicaid moms narrowed by 5 percentage points for CY07 compared to CY06.

Local MH contract agencies provide presumptive eligibility. Local agency activities involved in increasing the number of women who enter prenatal care in the first trimester include a public awareness campaign; outreach presentations to churches, schools, and community centers; flyers distribution to pregnant women; WIC and MCH staff providing follow-up contacts; and school nurses providing information on the MH programs encouraging education on early prenatal care. In FFY09, several agencies plan to offer free

pregnancy tests to improve early identification of adolescent pregnancies. This information is shared with local school nurses to help increase awareness and referrals for pregnancy testing and prenatal care. //2010//

The report for HSCI #05C appears on Form 18.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	72.7	85	79.7

Notes - 2010
Data were obtained from 2007 Vital Statistics. We used the program written by NCHS to calculate these results

Narrative:
/2010/ The Medicaid claims file/birth certificate linked file for calendar year (CY) 07 was used to calculate the Kotelchuck index for Iowa mothers. Overall 79.7 percent of Iowa mothers received adequate PNC in CY07 compared to 83.1 percent in 2006. The reduction in adequate prenatal care is most likely a reflection of how data are collected on the 2003 revised birth certificate and the calculation that we used. Eight-five percent of non-Medicaid women received adequate prenatal care. The proportion of Medicaid mothers who received adequate prenatal care was 72.7 percent, more that ten percent lower than non-Medicaid mothers.

As discussed in the HSCI #4 narrative, local maternal health agencies use the Women's Health Information System (WHIS) to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. Software upgrades are expected to support incorporation of the updated Medicaid Risk Assessment from the Iowa Department of Human Services. //2010//

The report for HSCI #05D appears on Form 18.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's**	**YEAR**	**PERCENT OF POVERTY LEVEL**

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
/2010/ During 2008, the income eligibility guidelines for both Medicaid and hawk-i were 200% of FPL for infants 0 to 1. Iowa's hawk-i program allowed for a 20 percent disregard for earned income however, Medicaid eligibility did not. Consequently, only a very small number of infants were enrolled in hawk-i as Federal CHIP policies required that any child who applies for hawk-i but is eligible for Medicaid must be covered under Medicaid. During the 2008 legislative session, SF 389 was passed and signed by the Governor which effectively raised eligibility to 300% for infants in both Medicaid and hawk-i starting July 1, 2009. It is expected that infants should no longer be enrolled in hawk-i because the 20 percent disregard will not applied to this newly eligible population; this should eliminate the small inconsistencies between the two program's income eligibility requirements for infants. //2010//

The report for HSCI #06A appears on Form 18.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	200

Narrative:
/2010/ During 2008, the income eligibility guidelines for children on Medicaid were 133% FPL and 200% of FPL for the hawk-i program. With the passage of SF 389, the income guidelines for hawk-i was raised to 300% of poverty effective July 1, 2009. //2010//

The report for HSCI #06B appears on Form 18.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	200

Narrative:
/2010/ During 2008, the income eligibility guidelines for pregnant women on Medicaid were 200% of FPL. To align the Medicaid and hawk-i programs' income requirements, SF 389 increased income the eligibility for pregnant women to 300% starting July 1, 2009. //2010//

The report for HSCI #06C appears on Form 18.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes

Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
/2010/ Iowa's MCH program has increased access to WIC data for program planning. Administrators of the WIC and MCH programs have historically expressed the willingness to share appropriate data; however, the WIC program was not allowed to share data for non-WIC purposes according to federal guidelines. New rules were published by the US Department of Agriculture in the Federal Register on 9-27-2006. The new rules relaxed the federal guidelines on WIC data sharing, allowing state WIC agencies greater flexibility in sharing confidential applicant information with appropriate non-WIC agencies. In Iowa, a state plan has been written, policies have been developed, and approval has been obtained from the USDA regional office. After the federal requirements were completed, the IDPH programs covering WIC and MCH developed a memorandum of agreement to guide regular data integration activities.

Iowa's State Systems Development Initiative (SSDI) continues to devote its resources to ensuring that MCH program partners have access to policy and program relevant information. The implementation and analysis of the 2005 Iowa Child and Family Household Health Survey (HHS) is a priority SSDI initiative. The survey was a population-based statewide household telephone survey. The survey process began with a screening question to determine if the residence was home to a family with children. If so, the adult most knowledgeable about the health and health care of a randomly selected child under age 18 in the household was asked to complete the interview. The 180-question survey averaged 22 minutes to complete and surveyors obtained a 77 percent cooperation rate. Five reports containing analysis of the 2005 HHS have been posted to the Web at http://ppc.uiowa.edu/health/ICHHS/iowachild2005/ichhs2005.htm. The five reports addressed comprehensive statewide results (published in December 2006), early childhood results (published in the spring of 2007), children's health insurance (published in December 2007), nutrition and physical activity (published in the spring of 2008), and racial and ethnic disparities (published in April 2009). This population-based survey has provided important program-relevant data for local and statewide MCH agencies and will provide valuable information for the next Title V Five Year Needs Assessment.

IDPH obtained a grant from the March of Dimes to implement a PRAMS-like pilot project. The $10,000 grant funded a survey of several hundred new mothers four months after delivery and provided an understanding of the new mothers' post-partum behavior. The survey provided insights into possible relationships between lifestyles before birth and poor pregnancy outcomes, such as low birth-weight infants. The survey was called the Iowa Pregnancy Risk Assessment Monitoring System (I-PRAMS). //2010//

The report on HSCI #09A appears on Form 19.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No

Iowa Youth Survey	3	Yes

Notes - 2010

Narrative:

/2010/ In Iowa, The YRBSS is conducted by the Department of Education every two years in the odd numbered years. Participation in the YRBSS is hindered by the administration of the Iowa Youth Survey every three years. Schools are more opt to participate in the Iowa Youth Survey (IYS) than the YRBSS because they get local education agency data from the IYS. Iowa is moving toward administering the IYS every two years in the even numbered years to avoid this conflict and increase the participation in the YRBSS.

The Iowa Youth Tobacco Survey (IYTS) is conducted every two years. It is a comprehensive survey of tobacco use, secondhand smoke exposure, access, cessation, tobacco-related attitudes, tobacco marketing and tobacco prevention exposure and awareness of the JEL campaign among Iowa youth. The IDPH Division of Tobacco Use Prevention and Control conducts the IYTS to measure the effectiveness of youth tobacco-use prevention and cessation programs within Iowa. The IYTS results indicate that tobacco-use prevention efforts in Iowa have been successful. Youth tobacco use in Iowa declined by seven percentage points between the 2002 survey and the 2004 survey. The rate is well below the national average. //2010//

The report on HSCI #09B appears on Form 19.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The five-year plan for 2006-2010 places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a rural state with substantial shortages of medical services and maldistribution of existing services, Iowa is challenged to develop systematic approaches to population-based direct care services. In the past few years, program activities addressed improvement of access to services, identification of the needs of culturally diverse groups, and recognition of changes brought about by managed care. Additionally, activities for children and youth with special health care needs focus on assuring specialty services to children and families, integrating data systems, balancing private and public partnerships, and integrating community-based services. ***/2010/ As this five-year cycle has progressed, the Title V CSHCN program has regularly discussed and debated how best to proportion its resources among the four service levels of the MCH pyramid. This exercise has served to help keep lively the broad expectations and potential influences of our CSHCN program. //2010//***

B. State Priorities

DIRECT HEALTH CARE AND ENABLING SERVICES:

1. Need Statement: Assure access to pediatric specialty care for all children.

Analysis of the "2000 Iowa Child and Family Household Health Survey" provided information about the health status and related circumstances of families, both those with and without CYSHCN. Twenty-five percent of families with a CYSHCN had trouble getting specialty care when their child needed it. In contrast, but still notable, 11 percent of families without a CYSHCN had trouble accessing specialty care when needed. In the Title V needs assessment prioritization process, stakeholders ranked increased access to pediatric specialty care for all children as the #12 priority need.

2. Need Statement: Minimize developmental delay through early intervention services for children 0-3 years.

According to a report from the U.S. Department of Education, Office of Special Education Programs, Iowa's Early ACCESS system (Part C of IDEA) served 1.11 percent of Iowa's 0-1 year old children and 2.07 percent of Iowa's 0-3 year old children in 2004. Thus, Iowa met the OSEP recommendation that early intervention programs serve 1 percent of children 0-1 and 2 percent of children 0-3. In the Title V needs assessment prioritization process, increased access to early intervention services was ranked as the #3 priority need by stakeholders.

3. Need Statement: Assure developmental evaluations are provided to Medicaid enrolled children 0-5 years.

In Iowa, approximately 18,000 children ages 0-3 years need mental health services each year. This means that one in five young Iowans experience the signs and symptoms of mental disorders. According to a Commonwealth Report, "12 to 16 percent of children experience developmental problems, only one-third of those children - usually those with the most obvious conditions- are identified in pediatric practices prior to school entry." In the Title V needs assessment prioritization process, increased developmental evaluations for children 0-5 years was ranked as the #11 priority need by stakeholders.

According to data from the "2000 Iowa Child and Family Household Health Survey," 30 percent of families with CYSHCN and four percent of families without CYSHCN required behavioral or emotional care in the previous year. A review of the "Community Health Needs Assessment and

Health Improvement Plan" indicates that 14 counties are addressing mental health issues. Examples of priority issues for these counties are: poor access to services and health professionals, limited number of rural psychiatrists for adults and children, and inadequate mental health screening.

4. Need Statement: Improve the quality of family support and parent education programs and services.

Iowa currently does not have an integrated, comprehensive systemic approach to family support, home visitation, and parenting education. Most of Iowa's local home visiting programs and parenting education programs follow the model that meets the funding requirements. At the local level, Community Empowerment Areas are statutorily required to strive for spending 60 percent of their state funds on family support, home visiting, or parenting education. Community Empowerment Areas use a variety of national models and community-created models. Currently, Iowa supports the HOPES-HFI (Healthy Opportunities for Parenting to Experience Success -- Healthy Families) model through IDPH. Twelve counties use this home visiting model. Additional counties use a HOPES-like model for their home visiting program. Counties use the HOPES-like model because of the cost and lengthy accreditation process required by "official" HOPES-HFI Program. There are also 64 Parents as Teachers (PAT) programs throughout the state. The locally designed models generally do not include an evaluation component or preventive health component, both of which are included in more widespread evidenced-based models. In the Title V needs assessment prioritization process, improve the quality of family support and parenting education programs and services was ranked as the #9 priority need by stakeholders.

In the Community Health Needs Assessment and Health Improvement Plan, three counties are addressing parenting and family support issues. These counties will focus on unifying and improving availability of parenting education classes in their communities.

POPULATION-BASED SERVICES:

5. Need Statement: Improve the quality of primary care for children in Iowa.

Iowa's screening plan for preventive health services for children is consistent with standards established by the American Academy of Pediatrics. The periodicity schedule for comprehensive health screening for all children ages 12 months to 6 years includes testing for blood lead levels. Quality improvement reviews of preventive care records for Medicaid eligible children suggest that lead screening is likely to be the last component of the comprehensive screen to be completed. For this segment of the child health population, it appears that there is a correlation between the completeness of the recommended preventive health screen and testing for lead poisoning. Based on this observation, Iowa selected blood lead testing as an indicator of the comprehensiveness of primary care provided to children. The percentage of children receiving a blood lead test is identified as a proxy measure for the quality of primary care provided for children.

In 2000, the Iowa Department of Public Health started to examine elevated blood lead rates for birth cohorts. A birth cohort represents children who were all born in a given time period. The percentage of children tested and the prevalence of lead poisoning were determined for children under the age of six years. Data analysis for the 1998 birth cohort was complete as of December 31, 2004. Of 37,262 children born in 1998, 57.1 percent received a blood lead test before the age of six years. Of children who were tested, 7.5 percent had blood lead levels greater than 10 micrograms per deciliter (µg/dL), which is the blood lead level used to define lead poisoning. This is more than three times the national average of 2.2 percent. The Medicaid population is of special concern because the prevalence of lead poisoning in Medicaid children is 2.5 times the prevalence of lead poisoning in non-Medicaid children. In the Title V needs assessment prioritization process, stakeholders ranked improve the quality of primary care for children in Iowa as the #5 priority need.

The Community Health Needs Assessment and Health Improvement Plan from local boards of health indicated that 17 counties are addressing lead screening and follow-up. Most of the counties will focus on educating health care professionals and parents on the importance of lead screening for children under six years old.

6. Need Statement: Assure access to oral health care for children in Iowa.

Access to dental care for low-income families in Iowa is limited due to a number of barriers. These include: lack of financial resources to pay for care, lack of knowledge of the importance of good oral health, lack of dentists willing to see children under the age of three, shortage of dentists participating in the Medicaid program, shortage of dentists within the state, and issues of patient compliance.

In the "2000 Iowa Child and Family Household Health Survey," eight percent of responding families reported there was a time during the previous year that their child needed dental care, but could not obtain it. In the Title V needs assessment prioritization process, increased access to oral health services was ranked as the #6 priority need by stakeholders.

In the Community Health Needs Assessment and Health Improvement Plan, four communities are focusing on access to dental services for children, including Medicaid clients. Most of these communities will work with their local MCH agency to help with recruitment of dentists to treat all children at an earlier age.

7. Need Statement: Assure children enrolled in early care and education programs are in quality environments.

Iowa ranks in the top three states for percentage of children under age six whose parents are in the labor force. Seventy-seven percent of Iowa families with children 0-5 years old have both or the only parent working. The increase of working parents in the last decade has resulted in the need for child care arrangements for about 30,000 additional children. In the Title V needs assessment prioritization process, stakeholders ranked improve health and safety in child care and preschool as the #10 priority need.

According to the "2000 Iowa Child and Family Household Health Survey," almost half (46%) of Iowa children ages 10 and under receive child care from someone other than a parent. Four percent of parents of CYSHCN were very dissatisfied with their child care arrangements compared to only one percent of parents of other children. The parents of CYSHCN were more likely than parents of other children to report trouble finding child care when their child was sick (33% vs. 25%). About one-third of parents of CYSHCN had difficulty finding child care because of the child's special health care need.

The Midwest Research Consortium on Quality in Child Care documented the status of quality on Iowa's early care and education programs. A 2002 study found poorer quality infant and toddler care in both center-based and home-based care in Iowa compared to other Midwest states. The study concluded that at the time of the survey, Iowa had fewer statewide initiatives to support quality or professional development of the child care workforce than other midwest states.

INFRASTRUCTURE BUILDING SERVICES:

8. Need Statement: All children and adolescents should be physically active for at least 30 minutes, limit screen time to no more than two hours, and eat five or more servings of fruits and vegetables each day.

According to the "2002 CDC Pediatric Nutrition Surveillance System," 30 percent of low-income children aged 2-5 years in Iowa are overweight or at risk of becoming overweight and 61 percent

of Iowa adults are overweight or obese. In Iowa, the obesity rate in adults has increased by 70 percent from 1990 to 2002. In the needs assessment prioritization process, stakeholders ranked improve physical fitness of children as the #4 priority need.

A review of submitted Community Health Needs Assessment and Health Improvement Plans revealed a collective top priority of related factors: overweight, nutrition, and physical activity. There are 63 counties focusing efforts around these issues.

9. Need Statement: Reduce the number of infant deaths due to prematurity.
Infant mortality is a critical indicator of the health of a population, as it reflects the overall state of maternal health, as well as the quality and accessibility of primary health care available to pregnant women and infants. Advances in medical technology and access to care have produced declines in infant mortality rates across the country, including Iowa. In the Title V needs assessment prioritization process, reduce infant mortality was ranked as the #8 priority need by stakeholders.

Provisional data for calendar year 2004 points to a potential decrease in the rate of infant mortality per 1,000 births, from 5.7 in 2003 to 5.0 in 2004.

In the Community Health Needs Assessment and Health Improvement Plan, 15 counties are addressing prenatal care and birth outcomes.

10. Need Statement: Assure pregnant and parenting women are screened and referred to appropriate mental health services.

The IDPH Women's Health Information System contained records for 9,344 women in 2004. The top needs listed by the women were emotional and social needs (7.6 percent), language/cultural barriers (3.9 percent), and domestic violence assistance (3.1 percent).

A review of the Community Health Needs Assessment and Health Improvement Plan indicated that 14 counties are addressing mental health issues such as poor access to services and health professionals, limited number of rural psychiatrists for adults and children, and inadequate mental health screening.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99.7	99.8	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	43	44	58	184	73
Denominator	43	44	58	184	73
Data Source					CCID and INMSP
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
FFY08 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

Notes - 2007
FFY07 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

Notes - 2006
FFY06 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

a. Last Year's Accomplishments
The performance objective of 100 percent was met. Data provided to the Center for Congenital and Inherited Disorders (CCID) and the Iowa Neonatal Metabolic Screening Program (INMSP) indicate that 100 percent of all eligible Iowa newborns that screen positive receive short-term follow-up through to confirmatory diagnosis, and long-term follow-up for clinical case management and treatment.

INFRASTRUCTURE BUILDING SERVICES: The CCID continued its active participation with seven other states in the Heartland Regional Genetics and Newborn Screening Collaborative to develop standards of care, educational programs and sharing of best practice models for genetic and newborn screening services provided in the region.

The CCID also remains active in the Connections program for data integration through the Public Health Informatics Institute. This collaboration evaluates opportunities for data analyses, evaluation and integration. The CCID works with the data/information management liaison from the Bureau of Family Health in this effort. The state genetics coordinator participated in a Connections subcommittee that developed a business case model for newborn screening programs. This model is now being used nationwide as a foundation for newborn screening information system development.

The Web page for the CCID is http://www.idph.state.ia.us/genetics. Fact sheets for various inborn errors of metabolism have been posted to the Web page and are updated on a regular basis.

An Executive Team consisting of the state genetics coordinator, the newborn screening program medical director, the screening laboratory director and the newborn screening program administrative assistant was established. This team reviews fiscal status of the program, makes policy recommendations, reviews current disorders provided by the screening panel for efficacy and reviews and makes recommendations to the advisory committee and IDPH regarding other disorders to add to the screening panel.

Iowa's 2008 82nd General Assembly decreased the state appropriation to the Metabolic Formula and Medical Foods program by $100,000 for SFY09. The University of Iowa's Metabolic Formula and Medical Foods programs initiated a work plan to distribute funds for the purchase of medical foods to program participants.

Newborn metabolic screening records are matched with birth certificate records to identify newborns that were not screened. A database identifies unscreened newborns and infants by matching birth records to laboratory records. When an unscreened newborn is identified, the birthing facility and/or physician's office is contacted to determine the reason that the newborn

was not screened. If a missed screening was identified, screening was arranged.

The INMSP follow-up system provides centralized short-term follow-up services that manage cases from presumptive positive test results through to confirmatory diagnosis and linkage with a medical home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to allocate funds for the purchase of medical foods and metabolic formula.	X			
2. Promote development of data integration/linkages with birth certificate, laboratory, healthcare providers and newborn hearing screening program.				X
3. Implement newborn screening surveillance program.				X
4. Continue to engage communities and healthcare providers in the planning, implementation and evaluation of newborn screening programs.		X		X
5. Monitor newborn metabolic follow-up program for referral patterns and linkages with medical home.			X	X
6. Evaluate conditions for addition to the universal newborn screening panel.			X	
7.				
8.				
9.				
10.				

b. Current Activities

POPULATION-BASED SERVICES: The INMSP is a fee-for-service program that provides laboratory, follow-up, consultative and educational services. Responsibility for the Neonatal Metabolic Screening testing is assigned to the University Hygienic Laboratory at the University of Iowa. The U of I Newborn Metabolic Screening program staff provides follow-up on positive screens. All newborns are screened for medium chain acyl Co-A dehydrogenase deficiency, phenylketonuria, and other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry; hypothyroidism; galactosemia; hemoglobinopathies; congenital adrenal hyperplasia; biotinidase deficiency; and cystic fibrosis.

A HRSA-MCHB grant awarded to IDPH provides support for the Iowa Family Participation Project (IFPP). The IFPP aims to ascertain the awareness and perceptions of community members and primary care providers of the newborn screening programs in Iowa. The main goal is to increase parent participation in planning, implementing and evaluating the newborn screening programs.

IFPP staff conducted workgroup sessions with representatives of communities including Amish, Sudanese immigrants, chiropractic college affiliates, adoptive/foster parents and parents of children with a positive newborn screening result (false positive, true positive and carrier positive). Analyses of the workgroup sessions are being conducted to examine common themes, perceptions and needs of the different communities.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: The CCID will continue to work with the Information Management Bureau within IDPH to explore the feasibility of integrating data analysis, such as

screening rates, between the neonatal metabolic screening program and the newborn hearing screening programs. The objective would be to assure every child receives comprehensive newborn screening.

The director of the information management section at the University Hygienic Laboratory is currently working with a national group to expand HL7 messaging capacity for the newborn screening programs and healthcare providers. This will cultivate a coordinated electronic notification and follow-up system.

The IDPH CCID was awarded a grant from the Centers for Disease Control and Prevention (CDC) to expand the existing Iowa Registry for Congenital and Inherited Disorders (IRCID) to include confirmed newborn screening cases. Implementation has begun via case identification by the long-term follow-up programs, the UHL and Early Hearing Detection and Intervention (EHDI) programs. As cases are identified, the IRCID is notified, and provided with data from program-specific data collection tools. IRCID will also conduct active surveillance from hospital discharge records. This project will greatly enhance the newborn screening programs' capacity to monitor follow-up and referral patterns.

The IFPP will be in the third and final project year in FFY10 and will focus on maintaining community engagement and program evaluation.

A neonatal metabolic screening program regional coordinator has been hired, and will begin work to provide coordination, education and quality assurance services to North Dakota and Iowa. The regional coordinator will promote and assess quality newborn screening testing of birthing providers, the follow-up programs and the testing laboratory. The coordinator provides annual and as-needed reports to the state genetics coordinator.

The state genetics coordinator will conduct a review of the newborn screening program to ascertain adherence to policies and procedures and assess efficiency.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	59.9	60.6	61.3	62	65.1
Annual Indicator	58.6	58.6	58.6	64.7	64.7
Numerator	225	225	225		
Denominator	384	384	384		
Data Source					NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	66.4	67.7	69.1	70.5	71.9

Notes - 2008

Annual indicator value is from '05-'06 NS-CSHCN. Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to partner in decision making.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every five years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

a. Last Year's Accomplishments
The FFY08 performance target objective of 65.1 percent was not met. The indicator value for Iowa was 64.7 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 5th highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, family participation program leadership was a standard participant in and contributor to all Title V CYSHCN Program strategic planning and high level decision-making.

CHSC family participation program leadership continued to recruit parent consultant network colleagues to formulate and influence public policy relevant to service systems for children with special health care needs.

Family involvement was a major strategy in the SAMHSA-supported System of Care development effort co-led by CHSC to improve services for children with severe emotional disorder.

DIRECT AND ENABLING SERVICES:

The family participation program in CHSC maintained a roster of over 30 parents of children with special health care needs working in five major program areas -- regional clinic programs; Medicaid Waivers and EPSDT; Part C service coordination; SAMHSA-supported system of care project; and the Early Hearing Detection and Intervention project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family participation by two CHSC parent consultants continues on the CHSC leadership council, the primary strategic planning team in the organization.				X
2. A CHSC community-based parent consultant serves on a governor-appointed statewide Medicaid advisory committee.				X
3. The CHSC co-led SAMHSA-supported System of Care project				X

adheres to "family-driven" and "youth-guided" principles.				
4. One parent leader of the CHSC parent consultant network attended the Association of Maternal and Child Health Programs national conference to both participate in the workshops and advocate with Iowa's federal legislators.				X
5. CHSC staff wrote and submitted a grant requesting support for a statewide, family-led, multiagency Family-to-Family Health Information Center.				X
6. Family participation in CHSC continued to maintain a roster of over 30 parents of children with special health care needs working in five major program areas -- regional clinic programs; Medicaid Waivers and EPSDT; Part C service coordination; SAMHSA	X	X		
7. Additional CHSC parent consultants are trained and function as newly paid "service coordinators" for young children enrolled in Iowa's IDEA Part C early intervention program.		X		
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES:

In FFY09, family participation by two CHSC parent consultants continues on the CHSC leadership council, the primary strategic planning team in the organization.

A CHSC community-based parent consultant serves on a governor-appointed statewide Medicaid advisory committee.

The CHSC co-led SAMHSA-supported System of Care project adheres to "family-driven" and "youth-guided" principles.

One parent leader of the CHSC parent consultant network attended the Association of Maternal and Child Health Programs national conference to both participate in the workshops and advocate with Iowa's federal legislators.

CHSC staff wrote and submitted a grant requesting support for a statewide, family-led, multiagency Family-to-Family Health Information Center.

DIRECT AND ENABLING SERVICES:

Family participation in CHSC continued to maintain a roster of over 30 parents of children with special health care needs working in five major program areas -- regional clinic programs; Medicaid Waivers and EPSDT; Part C service coordination; SAMHSA-supported system of care project; and the Early Hearing Detection and Intervention project.

Additional CHSC parent consultants are trained and function as newly paid "service coordinators" for young children enrolled in Iowa's IDEA Part C early intervention program.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES:

In FFY10, CHSC will continue to support and expand, as possible, CHSC's family participation

across all levels of the MCH pyramid.

CHSC will emphasize family participation program leaders and members in upcoming Title V needs assessment activities, including data interpretation of both the National Children w/ Special Health Care Needs Survey and the Iowa Child and Family Household Health Survey.

CHSC will lead implementation of the approved Family-to-Family Health Information Center grant proposal.

CHSC will continue to update CHSC's bank of family stories for use in program marketing and advocacy efforts.

DIRECT AND ENABLING SERVICES:

Family participation in CHSC will continue to maintain a roster of over 30 parents of children with special health care needs working in five major program areas -- regional clinic programs; Medicaid Waivers and EPSDT; Part C service coordination; SAMHSA-supported system of care project; and the Early Hearing Detection and Intervention project.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	59.4	60.6	61.8	63	60.3
Annual Indicator	57.1	57.1	57.1	57.4	57.4
Numerator	413	413	413		
Denominator	723	723	723		
Data Source					NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	61.5	62.7	64	65.3	66.6

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the medical home model.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Although, we did not meet the 2007 target, we are encouraged to set increasing target objectives based on the assumption that recent 2008 health care reform state legislation will have a strong positive influence on primary care providers to pursue a medical home model of care delivery.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every five years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

a. Last Year's Accomplishments
The FFY08 performance target objective of 60.3 percent was not met. The indicator value for Iowa was 57.4 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 1st among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, the Iowa Medical Home Initiative project activated two new partnerships with: 1) the Iowa Dept of Public Health 1st Five project emphasizing improved early childhood developmental screening and referral practices by primary care providers; and 2) the Iowa-Nebraska Primary Care Association (IA/NEPCA) to facilitate investigation of medical home model practices by Iowa's safety net providers (e.g. free clinics, MCH agencies, and local boards of health).

As part of the IA/NEPCA partnership, CHSC led two workshops to present the medical home model and related state legislation to interested safety net provider organizations.

CHSC medical home initiative staff collaborated with the 1st Five project to promote early childhood developmental screening and referral as a quality improvement effort that could be expanded to wider medical home-related improvement strategies.

The IMHI was a resource to the Iowa Affordable Health Care Commission medical home workgroup and formulated a set of medical home designation criteria with suggested training resources for use by the director of the Iowa Department of Public Health.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CHSC-led Iowa Medical Home Initiative (IMHI) continues a collaboration with the Iowa Department of Public Health's 1st Five Program to provide developmental-oriented consultation to primary care practices, as well as any requested consultation on				X
2. The IMHI continues a partnership with the Iowa-Nebraska Primary Care Association to provide technical assistance to selected safety net providers involved in fulfilling a legislative mandate to help Iowa families "determine a medical home."				X
3. CHSC staff collaborated with a graduate student who analyzed the fit between the medical home model and safety net provider organizations, especially free medical clinics, culminating in a presentation to the Executive Board of the Free				X

Clinics of Io				
4. CHSC staff participate as consultants to and members of the legislatively mandated Medical Home System Advisory Council to implement the medical home-related components of statewide health care reform.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES:

In FFY09, the CHSC-led Iowa Medical Home Initiative (IMHI) continues a collaboration with the Iowa Department of Public Health's 1st Five Program to provide developmental-oriented consultation to primary care practices, as well as any requested consultation on care coordination and the medical home model.

The IMHI continues a partnership with the Iowa-Nebraska Primary Care Association to provide technical assistance to selected safety net providers involved in fulfilling a legislative mandate to help Iowa families "determine a medical home."

CHSC staff collaborated with a graduate student who analyzed the fit between the medical home model and safety net provider organizations, especially free medical clinics, culminating in a presentation to the Executive Board of the Free Clinics of Iowa.

CHSC staff participate as consultants to and members of the legislatively mandated Medical Home System Advisory Council to implement the medical home-related components of statewide health care reform.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES:

In FFY10, CHSC will continue collaborations with the IDPH 1st Five Program and the Iowa-Nebraska Primary Care Association Safety Net Provider projects to fulfill any requested consultation on care coordination and the medical home model.

CHSC will make its expertise available and position itself as a potential partner for any state or regional efforts to spread the medical home model in accordance with the legislative requirements of Iowa's new health care reform bill.

CHSC will be a leader in spreading the medical home model for benefit of young children as supported by Iowa's Early Childhood Initiative strategic plan and the Off to a Good Start Coalition.

CHSC strategic plans will promote, through the work of a medical home-care coordination workgroup, stronger, more effective connections between Iowa's primary care providers and community-based care coordination resources.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	63.3	67.7	71.1	74.7	72
Annual Indicator	64.5	64.5	64.5	68.6	68.6
Numerator	468	468	468		
Denominator	726	726	726		
Data Source					NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73.4	74.9	76.4	77.9	79.5

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to have adequate public and/or public insurance.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Although we did not meet the 2007 target, we set increasing target objectives because of the consistently and broadly acknowledged high importance of this insurance-related outcome priority.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

a. Last Year's Accomplishments
The FFY08 performance target objective of 72.0 percent was not met. The indicator value for Iowa was 68.6 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 4th highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, the Iowa Medical Home Initiative continued informal connections with third-party payers and policy advocates regarding innovative chronic illness management practices consistent with a high quality, cost-effective medical home standard of care for children with special health care needs.

CHSC provided input to a statewide policy advocacy organization seeking to maintain Iowa's State Children's Health Insurance Program (SCHIP) coverage and to enhance the quality of care provisions under SCHIP authorization language.

CHSC was a planning partner in a statewide early childhood advocacy effort - the "Off to a Good Start Coalition" - that promotes the health-related goals of Iowa's Early Childhood Comprehensive Systems project, one of which is to assure adequate health and dental insurance coverage.

DIRECT AND ENABLING SERVICES:

CHSC regional centers worked with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.

CHSC's Health & Disease Management unit provided guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC continues to provide staffing to the Covering Kids and Families Coalition, whose mission is to assure coverage for all Iowa children and families.				X
2. CHSC participates on and suggests activities for the "Off to a Good Start Coalition" which has as one major goal, the assurance that young children are adequately insured.				X
3. CHSC is a participant and reviewer of the Iowa Child and Family Household Health Survey special report on insurance status of Iowa families.				X
4. CHSC participates on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.				X
5. A CHSC community-based parent consultant serves on a Governor-appointed statewide Medicaid advisory committee.				X
6. CHSC regional centers work with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.		X		
7. CHSC's Health & Disease Management unit continues to provide guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.		X		
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, CHSC continues to provide staffing to the Covering Kids and Families Coalition, whose mission is to assure coverage for all Iowa children and families.

CHSC participates on and suggests activities for the "Off to a Good Start Coalition" which has as one major goal, the assurance that young children are adequately insured.

CHSC is a participant and reviewer of the Iowa Child and Family Household Health Survey special report on insurance status of Iowa families.

CHSC participates on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A CHSC community-based parent consultant serves on a Governor-appointed statewide Medicaid advisory committee.

DIRECT AND ENABLING SERVICES:

CHSC regional centers work with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.

CHSC's Health & Disease Management unit continues to provide guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY10, CHSC will continue to provide staffing to the Covering Kids and Families Coalition, whose mission is to assure coverage for all Iowa children and families.

CHSC will participate, as requested, in any survey-based special reports (e.g. from the Iowa Child and Family Household Health Survey) on the insurance status of Iowa families.

CHSC will continue representation on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A CHSC parent consultant will continue participation on a Governor-appointed statewide Medicaid advisory committee.

CHSC will volunteer or agree to participate on any task force assembled by the Iowa Insurance Division to investigate improvement strategies in coverage for services to Iowa children with autism spectrum disorders.

DIRECT AND ENABLING SERVICES:

CHSC will continue to assist and enable families of children with special health care needs to apply for Medicaid or SCHIP.

CHSC's Health & Disease Management unit will continue to provide guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care

financing.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	81	82.6	84.3	86	93.8
Annual Indicator	77.8	77.8	77.8	92.9	92.9
Numerator	301	301	301		
Denominator	387	387	387		
Data Source					NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94.7	95.6	96.6	97.6	98.6

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve community-based service systems.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Although our data source for this NPM (the National CSHCN Survey) is only repeated every five years, we felt responsible to revise and raise the annual target objectives by a modest percentage as motivation to remain involved in system development efforts designed to improve families' easy use of community-based service systems.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

a. Last Year's Accomplishments

The FFY08 performance target objective of 93.8 percent was not met. The indicator value for Iowa was 92.9 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 2nd highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, CHSC state and regional staff participated in a SAMHSA-supported System of Care system improvement effort to develop a new, coordinated, family-driven system of care for children with severe emotional disorders.

CHSC staff supported the Iowa Dept of Public Health's 1st Five project to assure early childhood healthy mental development by helping primary care practices to both identify at-risk young children and link them to Title V community-based care coordination resources.

DIRECT AND ENABLING SERVICES:

The CHSC Health and Disease Management Unit continued to provide care coordination to children with complex health care needs enrolled in Medicaid Waiver and EPSDT Programs under a contract with the Iowa Department of Human Services.

Telehealth consultations between CHSC regional staff and medical center-based child psychiatry staff for children with difficult behavioral problems was increasingly utilized.

CHSC parent consultants functioned as service coordinators for young children with selected developmental conditions enrolled in Iowa's IDEA Part C program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC is developing a new approach to linking community-based care coordinators and primary care providers to ultimately improve health and systems outcomes.				X
2. CHSC continues a major role in a SAMHSA-supported System of Care project to improve access, delivery, and coordination of mental health services for children with severe emotional disorders.				X
3. Collaboration continues with the Iowa Dept of Public Health's 1st Five project to assure families of young children at-risk for developmental delay are connected to needed early intervention services.				X
4. CHSC continues to use telehealth technology to improve families' access to clinical services, especially for children with behavioral problems.	X			
5. CHSC's Health & Disease Management unit continues to provide care coordination to children enrolled in Medicaid Waiver and EPSDT programs via contract with the Iowa Dept of Human Svcs.		X		
6. Additional members of CHSC's parent consultant network have been trained and function as "service coordinators" for children enrolled in Iowa's IDEA Part C Program.		X		
7. CHSC parent consultants provide Guide By Your Side family	X	X		

support - specifically emotional support, information, and mentoring to children enrolled in the Early Hearing Detection and Intervention program.				
8. CHSC regional staff are engaging in a pilot program to systematically, competently, and efficiently provide care coordination services to community-based primary care providers.		X		
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES:

In FFY09, CHSC is developing a new approach to linking community-based care coordinators and primary care providers to ultimately improve health and systems outcomes.

CHSC continues a major role in a SAMHSA-supported System of Care project to improve access, delivery, and coordination of mental health services for children with severe emotional disorders.

Collaboration continues with the Iowa Dept of Public Health's 1st Five project to assure families of young children at-risk for developmental delay are connected to needed early intervention services.

DIRECT AND ENABLING SERVICES:

CHSC continues to use telehealth technology to improve families' access to clinical services, especially for children with behavioral problems.

CHSC's Health & Disease Management unit continues to provide care coordination to children enrolled in Medicaid Waiver and EPSDT programs via contract with the Iowa Dept of Human Svcs.

Additional members of CHSC's parent consultant network have been trained and function as "service coordinators" for children enrolled in Iowa's IDEA Part C Program.

CHSC parent consultants provide Guide By Your Side family support - specifically emotional support, information, and mentoring to children enrolled in the Early Hearing Detection and Intervention program.

CHSC regional staff are engaging in a pilot program to systematically, competently, and efficiently provide care coordination services to community-based primary care providers.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES:

In FFY10, CHSC will continue availability and involvement in developing statewide programs to improve the identification, early intervention, and care coordination for children with autism and autism spectrum disorders.

CHSC will continue to fill a major role in the SAMHSA-supported System of Care multiagency effort to improve access, delivery, and coordination of mental health services for children with severe emotional disorders.

CHSC will continue collaboration with the Iowa Dept of Public Health's 1st Five project to assure that families of young children at-risk for developmental delay are connected to needed

community-based early intervention services.

DIRECT AND ENABLING SERVICES:

CHSC will continue to utilize the Health & Disease Management unit to provide care coordination to children and families enrolled in Medicaid Waiver and EPSDT programs via contract with the Iowa Dept of Human Services.

CHSC will continue to provide - and expand if necessary - service coordination to selected young children with special health care needs enrolled in Iowa's IDEA Part C Program and their families.

CHSC will continue participation in the Guide By Your Side program to provide family support, emotional support, information, and mentoring to children enrolled in the Early Hearing Detection and Intervention program.

CHSC will expand pilot care coordination efforts to all CHSC regional staff with intention of systematically, competently, and efficiently providing care coordination services to community-based primary care providers needing assistance.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		6.4	7	7.7	49.7
Annual Indicator	5.8	5.8	5.8	47.3	47.3
Numerator	310	310	310		
Denominator	5351	5351	5351		
Data Source					NSCSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50.7	51.7	52.7	53.8	54.9

Notes - 2008
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the transition services.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006

CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

We are hoping that participation in a technical assistance experience will boost our Title V CSHCN Program's accomplishments for this national priority outcome.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every five years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

a. Last Year's Accomplishments
The FFY08 performance target objective of 49.7 percent was not met. The indicator value for Iowa was 47.3 percent based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 11th highest among U.S. states and statistically significantly better than the national mean. Although a good ranking nationally, CHSC believes the indicator value is unsatisfactory, so has set a higher target objective to motivate performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, a CHSC task force identified adolescent transition as a specific medical home component in a document prepared for the director of the Iowa Department of Public Health for use in designating primary care practices as medical homes.

An adolescent specialist pediatrician affiliated with the Iowa Medical Home Initiative presented adolescent transition as part of a CHSC-led learning session specifically designed for Iowa safety net providers pursuing adoption of medical home model components.

CHSC co-led a SAMHSA-supported mental health System of Care project, which, according to family-driven and youth-guided principles, stands to be instrumental in facilitating effective transition for youth to adult care and independent living.

CHSC staff provided program-related consultation to MCH epidemiologists undertaking a study (using National Children with Special Health Care Needs Survey data) to investigate associations between individual, condition-related, and systems variables and prevalence of family-reported successful or unsuccessful receipt of transition services.

DIRECT AND ENABLING SERVICES:

CHSC nurse care coordinators assisted families with eligible adolescents to enroll in Medicaid Waiver programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC staff include adolescent transition services as one topic or activity whenever making presentations to primary care practices or other organizations about the medical home model.				X

2. CHSC co-leads a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.				X
3. CHSC provides program-related consultation to MCH epidemiologists undertaking a study (using National Children with Special Health Care Needs Survey data) for a peer-reviewed publication investigating associations between individual, condition-relate				X
4. CHSC's Health & Disease Management Unit assists families choose and enroll adolescents with special health care needs in Medicaid Waiver programs and, when relevant, address transition issues, e.g. linking adolescents to Vocational Rehabilitation ser		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES:

In FFY09, CHSC staff include adolescent transition services as one topic or activity whenever making presentations to primary care practices or other organizations about the medical home model.

CHSC co-leads a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.

CHSC provides program-related consultation to MCH epidemiologists undertaking a study (using National Children with Special Health Care Needs Survey data) for a peer-reviewed publication investigating associations between individual, condition-related, and systems variables and prevalence of family-reported successful or unsuccessful receipt of transition services.

DIRECT AND ENABLING SERVICES:

CHSC's Health & Disease Management Unit assists families choose and enroll adolescents with special health care needs in Medicaid Waiver programs and, when relevant, address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES:

In FFY10, CHSC staff will continue to include adolescent transition services as one topic or activity whenever making presentations to primary care practices or other organizations about the medical home model.

CHSC will continue to co-lead a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.

CHSC will partner in implementation - if approved - of a federal grant proposal (Family 360 project) to assure smoother, more effective transition of adolescents to adult health care and,

ultimately, successful independent living.

DIRECT AND ENABLING SERVICES:

CHSC's Health & Disease Management Unit will continue to assist families choose and enroll adolescents with special health care needs in Medicaid Waiver programs and, when relevant, address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	91	94	95	95	90
Annual Indicator	93.6	94.3	94.6	88.4	72.8
Numerator	5968	5757	5469	5116	3930
Denominator	6374	6105	5781	5786	5395
Data Source					PSIA report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	74	76	78	80	80

Notes - 2008
2008 Data were obtained from the 2009 Public Sector Immunization Assessment report. The decrease in the percentage of children fully immunized between 2007 and 2008 can be attributed to a change in assessment protocol as well as the national Hib shortage.

Notes - 2007
Data were obtained taken from the 2008 Public Sector Immunization Assessment report.

Notes - 2006
Data were obtained taken from the 2007 Public Sector Immunization Assessment report.

a. Last Year's Accomplishments
The FFY08 performance measure of 90 percent was not met. Data from January through December 2008 indicate that 72.8 percent of the children assessed in public sector clinics were appropriately immunized by age two. The decrease in the percentage of children fully immunized between last year (88 percent) and this year (72.8 percent) can be attributed to a change in assessment protocol as well as the national Hib shortage.

In addition to counting the number of doses, assessments also reviewed the intervals between doses to assure that minimum age and intervals had not been violated. If a minimum interval had been violated, the dose was not valid and the child was not counted as up-to-date. Doses of vaccine that are spaced too closely together and violate the minimum interval spacing are not

valid and require re-vaccination at the proper interval for the child to be fully protected. The Iowa Immunization Program follows CDC assessment guidelines and the Advisory Committee on Immunization Practices (ACIP) recommendations on the minimum interval spacing as published on the Recommended Immunization Schedule for Persons Ages 0-6 Years and the Catch-Up Immunization Schedule.

The national Hib shortage required Iowa providers to defer the "booster" dose of Hib vaccine, typically given at 12-24 months of age, for non-high risk children. Upon assessment, the number of children completing the full schedule of immunizations was reduced, in part because of the Hib deferral. Children who were deferred, and are still within the recommended age range for vaccination, are to be recalled and vaccinated once the shortage ends. IDPH Immunization Program follows CDC guidelines for deferral and recall of children during the Hib shortage.

INFRASTRUCTURE BUILDING SERVICES: Collaborative efforts continued between IDPH Bureaus of Family Health and Immunization and Tuberculosis, and the Iowa Department of Human Services to improve immunization monitoring in Iowa.

POPULATION-BASED SERVICES: There were 99 new providers enrolled in the Immunization Registry Information System (IRIS) in 2008. As a result, 712 immunization clinics throughout Iowa utilized IRIS to record immunizations given in local public health agencies, community health centers, primary care practices, pharmacies and hospitals. As of December 31, 2008, 221,880 children at least four months of age and under age six had records in IRIS, representing 100% of the state population of this age cohort. Caution should be exercised in interpreting this percentage; while there are enough records in IRIS to produce a 100 percent rate, IDPH continues to address the issue of duplicate records in the registry. Duplicate records are not unique to IRIS and all state immunization registries continue to address this complicated issue.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recruit new private practice physicians to use the IRIS data system.				X
2. Provide immunization training and in services for VFC providers.				X
3. Continue to provide technical assistance to local maternal and child health, WIC, and public health agencies.				X
4. Collaborate with the Dept of Education on data exchanges to assure complete immunization records.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Funding is provided to local public health agencies and community health centers for immunization services. Some agencies conduct satellite clinics and collaborate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to provide immunizations. All primary care providers are encouraged to use IRIS. As of December 31, 2008 there are 712 providers enrolled in IRIS. This includes 374 private providers, 272 public providers, 45 hospitals, and 21 pharmacies. Public providers include local public health agencies, local CH contract agencies, Federally Qualified Health Centers/Rural

Health Clinics, and other public clinics that provide immunizations. Local CH contract agencies continue to monitor immunization status and offer counseling to families receiving EPSDT care coordination services. This includes Title XIX/Medicaid clients not served by an HMO.

In 2008, 20 regional IRIS classes were held in Iowa. The training provides hands-on learning and reiteration of skills to maintain and build IRIS capacity use through both public and private providers in the state.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES: The number of private providers using IRIS will continue to increase due to outreach of the Immunization Bureau. Local CH contract agencies will continue to monitor immunization status and offer counseling to all families served.

All local CH contract agencies will address immunization as a component of informing and care coordination provided to families enrolled in Medicaid.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	15	14.7	14.7	16	15
Annual Indicator	14.8	16.1	16.7	15.6	16.8
Numerator	895	963	999	973	1025
Denominator	60369	59906	59906	62364	61192
Data Source					Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16	15.5	15	15	15

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

a. Last Year's Accomplishments
The FFY08 performance objective of 15 per 1,000 was not met. Iowa's 2008 Vital Statistics provisional data indicates the birthrate for teenagers ages 15-17 was 16.7 per 1,000 live births.

The trend of increasing teen births in Iowa mirrors that seen nationally. The increase in teen pregnancy is in part a reflection of the decline in contraceptive use. The teen pregnancy rate is also influenced by educational and economic opportunities, income disparities, and social mores. The current economic downturn may have contributed to the increased teen pregnancy rate in Iowa.

INFRASTRUCTURE BUILDING SERVICES: Governor Chester Culver announced on February 29, 2008 that Iowa would reject any future federal funding for the Section 510 Abstinence Education Program in its current form. Iowa's program continued to operate on extension funding through June 30, 2008 at which time program services ceased. Remaining funds were returned to the Administration for Children and Families (ACF), DHHS.

Due to two short-term federal program extensions through June 30, 2008, an FFY08 federal grant application was not required of ACF grantee states. Existing community-based agencies were offered and accepted contract extensions. Continuation funding was made available to the seven existing sub-grantees for abstinence education programming, in addition to the University of Iowa School of Social Work for evaluation services. The Section 510 Abstinence Education project continued to implement programs for adolescents and adults ages 12 through 29, with a focus on age 12 to 18. Programming included curriculum-based instruction, community involvement, mentoring, peer education, parent workshops and media initiatives.

The Iowa Abstinence Education Program continued its involvement in the Abstinence Till Marriage (ATM) Coalition, comprised of over 25 state abstinence education leaders from across the nation. The goal of the ATM Coalition is to identify one or more projects that can be promoted on a national level with participation of state coalitions and other interested abstinence organizations. The coalition held monthly conference calls to discuss: current state projects, national projects, state coalitions, state advisories, federal reauthorization and state funding. The coalition served as a forum for sharing best practices, updating state leaders on national efforts in the abstinence until marriage campaign and gaining support from fellow advocates.

Iowa continued research on science-based practices in pregnancy prevention. Science-based practices include techniques, characteristics, activities and programs for which there is evidence of effectiveness. "Science-based" refers not only to the type of program but also to the process for developing a program.

In 2006, DHS received approval from the Centers for Medicare and Medicaid to implement a program, the Iowa Family Planning Network (IFPN), which waives section 1115 of the Medicaid rules. IFPN was implemented on February 1, 2006. The program extends Medicaid coverage for only family planning services to women who had Medicaid covered pregnancies and deliveries and to all women ages 13 to 44 whose income is below 200 percent of federal poverty. Information for eligibility determination for this program is obtained at family planning clinics as well as DHS offices. The notice of determination of eligibility for the program and clinical services can be obtained at the family planning clinic from DHS the day a woman applies for the program. Almost all of the women determined eligible for the program applied at family planning clinics.

ENABLING SERVICES: IDPH contracted with eight Title X Family Planning (FP) programs to conduct outreach and educational programs in 45 of Iowa's 99 counties. Developmentally appropriate educational programs stressed the value of abstinence, encouraged communication with parents, emphasized responsible decision making, avoidance of coercive sexual activity and information on pregnancy and STD/HIV. A focus of FP programming was clinical services to adolescents (ages 20 or younger). One of the goals for the FP program was to maintain the number of adolescents served at least 5,277 (CY 2004) clients. Calendar year 2008 showed an increase in the number of adolescents ages 20 and under, which reversed the prior two years' declines in numbers served.

Calendar Year	2004	2005	2006	2007	2008

adolescents 5277 5030 4892 4821 5002

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assuring ongoing high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.	X	X	X	
2. Assuring access to a broad range of acceptable and effective family planning methods and related preventive health services.	X	X	X	
3. Assuring compliance with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.			X	X
4. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.	X	X	X	X
5. Addressing the comprehensive family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach and/or vulnerable populations, and partnering with other community-based health and social service provide		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As the Section 510 Abstinence Education Program in Iowa ended June 30, 2008, no abstinence only education activities are being implemented in FFY09.

During FFY09, the overall Family Planning objectives remain focused on improving the quality and quantity of services to Iowa's three priority populations (minorities, adolescents and males); reducing the number of unintended pregnancies in Iowa and developing sustainable IDPH family planning clinics positioned to serve an increased number of clients.

During FFY09 IDPH applied for the Title X Supplemental Expansion Funds. The actual funds were not awarded until the last day of FFY09. IDPH requested, and was granted permission, to carry forward these funds. The focus for the expansion funds is increased awareness of the Title X programs through outreach and increased numbers of new, low income clients served. Six of eight IDPH delegate agencies are participating in the Supplemental Expansion Funds project.

c. Plan for the Coming Year

The Section 510 Abstinence Education Program is due for federal reauthorization in FFY11. If reauthorization or extension occurs, Iowa will re-evaluate the Section 510 program. If restrictions have been relaxed regarding the A-H guidelines, Iowa will determine if it will apply for future funding. IDPH will continue to provide information to all minors about all contraceptive methods, including abstinence.

IDPH will implement its objectives for year two of the five-year Title X plan, including the objectives for the Supplemental Expansion Funds and apply for FFY10 funding. IDPH Family Planning (FP) program has identified three priority populations: minorities, adolescents and males. Minorities and adolescents are disproportionately affected by reproductive health issues and the male role in family planning remains underestimated.
Plans to continue increasing outreach to teens include: 1) Developing and disseminating best practices for working with adolescents, 2) Exploring the use of electronic media to reach adolescents and conducting programming assistance to enable DAs to use electronic media to reach youth, 3) Identifying and inviting representation of a teen on the state family planning Information and Education Committee, 4) Distribute Title X Services brochure to Iowa Department of Education staff for use in teacher training seminars on HIV/STI prevention and pregnancy prevention, and 5) collaborate with maternal health and child health staff to convene a panel of minority youth to discuss health care needs and ideas for making clinic youth-friendly.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	43	44	46	45	47
Annual Indicator	43.4	45.5	44.0	44.5	49.2
Numerator	14577	15500	15198	15446	17336
Denominator	33588	34064	34540	34709	35235
Data Source					third grade survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
The data was collected on the OHB sealant survey for third graders in 2008.

Notes - 2007
The OHB previously conducted an annual sealant survey to determine this rate for the past eight years. Based upon the results of the data collected, a careful evaluation of the statistical significance or cost effectiveness to continue the annual survey was done. A decision of repeating the survey every third year was made. The data consultant for Iowa's Title V application will continue to use the forecast formula to estimate the sealant rate every other year.

Notes - 2006
The OHB previously conducted an annual sealant survey to determine this rate for the past eight years. Based upon the results of the data collected, a careful evaluation of the statistical significance or cost effectiveness to continue the annual survey was done. A decision of repeating the survey every other year was made. The data consultant for Iowa's Title V application will continue to use the forecast formula to estimate the sealant rate every other year.

a. Last Year's Accomplishments
Based on an open mouth survey of third graders, the FFY08 performance objective of 47 percent was met. The dental sealant rate on permanent first molars is 49.2 percent. The OHB plans to repeat the survey in two to three years and post the results at http://www.idph.state.ia.us/hpcdp/oral_health_reports.asp.

INFRASTRUCTURE BUILDING SERVICES: The Oral Health Bureau requested a Medicaid policy change regarding coverage of dental sealants. In response, the Department of Human Services proposed an amendment to their rules to include coverage of sealants on all posterior primary and permanent teeth. The amended rules were adopted and implemented on February 1, 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train primary care providers on the importance of sealants and fluoride varnish.			X	X
2. Provide training to community health center oral health staff.	X		X	
3. Continue to promote I-Smiles project and the state and local level.				X
4. Partner with local schools district on the implementation of the mandatory dental screen prior to school entry.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: Wellness and health care initiatives addressed the need for changes to SCHIP in order to allow families to enroll for dental coverage only. School-based dental sealant data from FY07 identified 26 percent of children with no payment source for dental care. This is consistent with data from previous years.

OHB is assessing oral health knowledge of Iowa families, with the assistance of a Targeted Oral Health Service Systems (TOHSS) grant. The assessment will be the basis for an oral health promotion campaign to be implemented in future TOHSS funding years. The campaign will include emphasis on the need for regular preventive dental care, particularly for children.

OHB supported a petition for a rule change to public health supervision, which may allow more children to receive dental sealants through school-based programs. In April, the Iowa Dental Board voted to change the rules, which will allow dentists and hygienists entering into agreements to determine the maximum length of time an exam by a dentist must occur following sealant application by the hygienist. The original rule limited the time to one year, which caused at-risk families to be limited to further care due to their inability to be seen in a dental office.

POPULATION-BASED SERVICES: Seven local CH agencies will receive funding to continue their school-based sealant programs through FFY10.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: The OHB's Targeted Oral Health Service Systems grant activities will include health promotion activities, with emphasis on preventive dental care. Following the end of the first year of the school dental screening requirement, OHB staff will begin review of the school audit report data. These data will include county and school district information about treatment needs and provider types, and will help determine if the screenings are impacting children's access to preventive and treatment services and demonstrate areas of need for focusing new oral health prevention efforts. Additional assessment will occur through CAReS. In February 2009, the CAReS system began to collect data regarding the presence of a dental sealant for children receiving dental screenings from Title V agency staff. Monitoring this information will assist OHB staff in sealant program development. OHB will continue to advocate for increasing the number of children with dental insurance, in order to assure families' access to preventive services, such as sealant application.

POPULATION-BASED, ENABLING, and DIRECT SERVICES: A final year of funding will continue for seven school-based sealant programs for children in grades two through eight. During school year 2007-08, 18,160 sealants were placed and over 4,600 students screened. School-based sealant programs will also continue within two Title V child health centers that initiated their programs using previous grant funds through OHB. Both centers have been able to maintain services using other sources of funds. As part of their I-Smile™ projects during FFY2010, two additional child health centers will begin planning for school-based sealant programs. In addition, one of the state's community health centers has secured funding and is collaborating with the local I-Smile™ coordinator to begin a sealant program during school year 2009-10.

During FFY10, the OHB will evaluate the school-based sealant program, as funded through IDPH, to determine if changes will be made prior to offering a competitive request for bid for the program in FFY11. Due to the sustainability of some projects, future funding may be limited to Title V child health centers that have not previously had a school-based sealant contract. OHB would then provide technical assistance to currently funded projects to transition them to maintain their programs without specific IDPH funds.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.4	5	4.1	2	4.5
Annual Indicator	6.7	4.4	2.1	4.6	2.9
Numerator	38	24	12	25	17
Denominator	569387	547627	581387	543571	586749
Data Source					Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	3	3	2	2	2

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

a. Last Year's Accomplishments
The FFY08 performance objective rate of 4.5 per 100,000 was met. Iowa Vital Statistics provisional data indicate the rate of death to children ages 14 and younger caused by motor vehicle crashes was 2.9 per 100,000.

POPULATION BASED SERVICES: The ‘Join the Click' and Commander Alex educational campaigns were designed to increase awareness of appropriate use of seat belts and the need for occupant protection among the "tweeners" population. An interactive booth was held at the Iowa State Fair to convey the message of occupant protection to both children and adults.

The University of Iowa Injury Prevention Research Center conducted the 2008 Iowa Child Passenger Restraint Survey. At locations across the state, 3,024 children ages 11 and under were observed in motor vehicles. The numbers indicate Iowans understand the importance of securing infants in child safety seats with 98.4 percent of children ages one and under appear to be properly restrained. It is also clear that older children are less likely to be restrained in the motor vehicle. Of older children, 96 percent of toddlers were restrained and 88 percent of youth were restrained. Overall, 92.2 percent of all children observed were restrained. The 2008 survey results show an overall increase of nearly three percent use in child restraints over the previous year. The increase in percentage of youth observed wearing restraints is an important improvement.

INFRASTRUCTURE BUILDING SERVICES: The Bureau of EMS-EMSC and Injury Prevention Programs worked with the Iowa Safe Kids Coalition and other nonprofit injury prevention organizations to support statewide child passenger safety check-ups at community events, as well as regularly scheduled child passenger safety inspection stations. During FFY08, certified technicians were available to inspect child passenger safety seats at 20 Fit Stations throughout the state. The Fit Stations hosted monthly events or served their community by appointment. A total of 450 new seats were distributed to families. Child passenger safety advocates worked to provide outreach to physicians, health care agencies, and child care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education to health care providers on car seat safety.				X
2. Provide child passenger safety check-ups across Iowa.	X		X	
3. Educate early care providers on the importance of car seat safety through child care nurse consultants.				X
4. Continue to be actively involved with the Iowa Safe Kids Coalition.				X
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: Physician outreach promoting child passenger safety continues. Physicians have the opportunity to educate families with young children about appropriate child passenger safety systems, and materials are provided at no cost. Outreach in child care settings and schools assure that a broad population receives education on appropriate occupant protection.

Youth outreach groups led by the Iowa Health System are presenting the "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

POPULATION BASED SERVICES: The Bureaus of Family Health and EMS-EMSC, and the Iowa Safe Kids Coalition are collaborating to provide outreach to childcare providers and families. Information regarding recalls of child safety seats and bicycle safety around cars is provided online. More information can be found on the HCCI Web site (http://www.idph.state.ia.us/hcci/products.asp).

Training continued for certified child passenger safety technicians. Four CPS certification trainings are scheduled for FY09. Technicians will also be trained at annual CPS Technician Workshop.

One local contract agency made decreasing child mortality related to motor vehicle accidents a priority. Focusing on distribution of car seat safety materials, certified car safety seat inspectors provide education and demonstrations at community events.

c. Plan for the Coming Year
POPULATION BASED SERVICES: Activities to decrease the mortality rate include a campaign focusing on pedestrian safety. The plan is to educate children on safe street crossing and proper utilization of sidewalks. Targeted interventions to encourage booster seat usage are also planned. A needs assessment will be completed and the results compiled in order to address the areas where education is needed. This education will involve demonstration of proper booster seat installation and booster seat checks. The requirements of Iowa law regarding booster seat usage will be discussed with parents. Booster seats will be made available at the site for those families who are in need.

Community outreach activities include "spot the tot" training, which teaches drivers to keep their eyes on children while backing up.

Updated car seat safety inspection cards will be developed. The car seat safety inspection cards will be distributed at community events.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective			28	35	46
Annual Indicator		27.5	34.7	20.1	20.0
Numerator		10496	103	2903	2927
Denominator		38133	297	14444	14633
Data Source					Pediatric NSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	22	24	25	25

Notes - 2008
2008 data is from the 2008 Pediatric Nutrition Surveillance Survey. The data show that 20 percent of the 14,633 infants in the data set were breastfed at six months of age.

Notes - 2007
2007 data is from the 2007 Pediatric Nutrition Surveillance Survey. The data show that 20.1 percent of the 14,444 infants in the data set were breastfed at six months of age.

Notes - 2006
Data were collected from the National Immunization Survey. Last year was the first year of collecting data on mothers who breastfeed their infants at six months. Iowa has decided to switch data sources from the Pediatric Nutrition Surveillance Survey data set to the National Immunization Survey.

a. Last Year's Accomplishments
The performance measure for FFY08 of 46 percent of mothers who breastfeed their infants at 6 months of age was not met. This objective was based upon data from the CDC National Immunization survey. The most recent data from this source is for 2005, whiched showed that 40.4 percent mothers breastfed their infants at 6 months of age. The 2008 data comes from the Pediatric Nutrition Surveillance Survey. These data show that 20 percent of infants in the dataset were breastfed at 6 months of age.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide technical assistance to local maternal and child health agencies on breastfeeding.				X
2. Co-sponsor the annual breastfeeding conference.				X
3. Continue to be involved with the Iowans Fit for Life Early Childhood workgroup to implement family friendly policy recommendations on breastfeeding.		X		X
4. Become involved with the Iowans Fit for Life Worksite workgroup to help implement worksites becoming breastfeeding friendly.		X		X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: The IDPH Bureau of Nutrition and Health Promotion requires local contract agencies to expend a minimum of 20 percent of the total allocated Nutrition Program for Women, Infants, and Children (WIC) funds on nutrition education, including a minimum of three percent of the WIC funds to be spent on breastfeeding promotion and support.

ENABLING SERVICES: The Bureau received a USDA-Peer Counseling grant since 2004. The purpose of the grant is to start a peer-counseling program in Iowa. One pilot projects was started in local WIC agencies in 2005. In 2008, four additional agencies started peer counselor programs. Evaluation of the peer agencies continue on a yearly basis. The five agencies currently have 21 peer counselors with each peer serving on average of 37 clients at any one time.

DIRECT HEALTH CARE SERVICES: All 20 WIC agencies, including 14 that integrate Title V services, implemented action plans targeting community-based breastfeeding promotion and support. Activities of local WIC contract agencies include: five Breastfeeding fairs for pregnant women held in 2009, Breastfeeding education and support to communities, agencies educating their community partners on a new food package being implemented by WIC on October 1, 2009 (this includes how breastfeeding women and their infants will be impacted) and Business Case for Breastfeeding (worksite) training and use thoughout the state.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: The Bureau of Nutrition and Health Promotion staff will provide technical assistance on breastfeeding to the local contract agencies. Local MH contract agencies will continue to develop and implement community-based strategies for breastfeeding. IDPH will continue to support the six agencies that have WIC breastfeeding peer counselor programs. Staff will also visit area businesses to discuss the breastfeeding guide.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	97	99	98	99.8	99
Annual Indicator	98.9	95.7	97.4	98.2	98.7
Numerator	15716	35757	37970	39684	39545
Denominator	15892	37360	38996	40414	40052
Data Source					eSP
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.5	99.6	99.7	100	100

Notes - 2008
The 2008 data were obtained from the eSP newborn hearing screening database. The total number screened may not include children that were not screened by the birthing hospital because they were transferred to another facility before screening, missed or the family refused. The total eligible for screening is birth by occurrence.

Notes - 2007
The 2007 data were obtained from the eSP newborn hearing screening data. The total number screened may not include children that were not screened by the birth hospital because they were transferred to another facility before screening, missed, or the family refused. The total eligible for screening is birth by occurrence.

Notes - 2006
The 2006 data were obtained from the eSP newborn hearing screening data. IDPH is in the process of implementing the eSP data system statewide. The total number screened may not include children that were not screened by the birth hospital because they were transferred to another facility before screening, missed, or the family refused.

a. Last Year's Accomplishments
The FFY08 annual indicator fell just short of the performance objective of 99 percent. The newborn hearing screening rate was 98.7 percent. Since 2005, the screening rate has continued to increase each year. The program has a Web based data system used for reporting; quality assurance checks are completed monthly.

EHDI continues to make great progress with screening, reporting and follow up of children who were missed or failed their newborn hearing screen at birth. The program continues to make referrals for children who were missed or failed their hearing screen and did not return for a follow up hearing screen by two months of age. The short delay allows the program to complete quality assurance checks to avoid unnecessary referrals, and gives families time to return for a follow up screen. The EHDI program has also worked with the Bureau of Health Statistics to obtain vital records data for home births each month.

IDPH was awarded a new three-year cooperative agreement with the Centers for Disease Control and Prevention in July 2008. The goals of the project are to: assure statewide implementation of the EHDI surveillance system; assure the quality and accuracy of reportable data; facilitate data sharing; integrate and link data with related screening, tracking and surveillance programs to minimize infants lost to follow-up and to evaluate the Iowa EHDI system based on National EHDI performance indicators. CHSC was also awarded new three-year grant from HRSA to focus on the timeliness of screening, follow-up services and referrals.

The English EHDI Family Resource Guide has been updated. The guides are distributed to audiologists serving children and are also made available at www.idph.state.ia.us/iaehdi.

An Iowa EHDI Best Practices Manual was also developed. The manual is intended to be used by birthing hospitals, Area Education Agencies (AEAs), primary care providers and private practice audiologists to develop programs and protocols for newborn hearing screening, follow up and intervention. The EHDI program piloted hospital site visits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to hospital, Area Education Agencies, health care providers and private practice				X

audiologists.				
2. Continue to monitor eSP data.				X
3. Use pediatric audiologist to provide technical assistance to facilities providing newborn screening.			X	
4. Provide training to early childhood professionals on childhood hearing loss.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: The EHDI Advisory Committee continues to meet on a quarterly basis.

The EHDI program updated protocols and developed a High Risk Monitoring Protocol for children with risk factors for hearing loss.

CHSC EHDI staff visited each AEA in an effort to reduce the number of children lost to follow-up and to increase participation in family support programs. The CHSC EHDI program facilitated a meeting of support groups for families of children with hearing loss, including population subsets such as the Amish community.

The Iowa EHDI program is participating in the "Improving the System of Care for Children and Youth with Special Health Care Needs: Epilepsy and the Newborn Hearing Screening Programs" Learning Collaborative through the National Initiative for Children's Healthcare Quality (NICHQ). Participation in NICHQ is expected to result in a reduction to the rate of children lost to follow-up.

POPULATION BASED SERVICES: There are 79 birthing hospitals providing universal newborn hearing screening services as required by law.

ENABLING SERVICES: The EHDI program continues to refer children needing initial hearing screenings or repeat screenings to Early ACCESS for follow-up. The EHDI program sends letters to families and physicians of children with risk factors for hearing loss to provide recommended follow-up protocol as well as provides family support services to families of children with hearing loss through the Iowa Guide by Your Side program

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: EHDI staff will continue their efforts to educate midwives about the importance of screening and follow-up for children who do not pass the initial screen or have risk factors for late-onset hearing loss.

Data sharing mechanisms will be implemented between EHDI and Early ACCESS to ensure children diagnosed with hearing loss are enrolled before 6 months of age. To ease data sharing between the two programs, EA service coordinators will be asked to obtain consent to release information at first contact so the information can be shared with the EHDI program.

The EHDI program will conclude participation in the NICHQ learning collaborative and work on spreading effective strategies to facilities across the state. EHDI will continue program evaluation on various aspects including hearing screening, follow-up, referral, early intervention, family support and data reporting. Evaluation results will be shared with the EHDI Advisory Committee.

POPULATION BASED SERVICES: All birthing hospitals will provide universal newborn hearing screening services as required by law. The EHDI program will participate in outreach and public education opportunities regarding the program.

ENABLING SERVICES: IDPH and CHSC will continue to work with Center for Disabilities and Development (CDD) audiologists to provide training to hospitals and AEA staff with an emphasis on "refer" and "miss" rates as well as follow-up.

The EHDI program will continue to work on improving the quality of and access to family support programs for families of children who are deaf or hard of hearing.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3	5	2	2.7	2.6
Annual Indicator	6.0	2.8	2.8	2.8	2.8
Numerator	41000	20640	19124	19919	19852
Denominator	683000	737212	683000	711403	709000
Data Source					Household Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.8	2.8	2.5	2.5	2.5

Notes - 2008
The annual indicator reflects the results of the 2005 Household Health Survey as noted in previous years. It remains difficult to estimate the percent of uninsured children in Iowa. Data from the most recent (2007) Census Population Survey (CPS) report the uninsured rate at 4.8%, however, variations in conflicting reports suggest errors in measurement and the use of differing data sources.

Notes - 2007
The numerator was obtained from the 2005 Child and Family Household Health Survey data. The denominator was obtained from the 2006 Census data for children <18 years.

Notes - 2006
The numerator was obtained from the 2005 Child and Family Household Health Survey data. The denominator was obtained from the 2005 Census data for children <18 years.

a. Last Year's Accomplishments
The FFY08 performance objective of 2.6 percent was not met. The indicator reflects the results of the 2005 Household Health Survey. It remains difficult to estimate the percent of uninsured children in Iowa. Data from the most recent (2007) Census Population Survey (CPS) report the

uninsured rate at 4.8 percent. However, variations in conflicting reports suggest errors in measurement and Iowa anticipates a decrease in the uninsured rate in upcoming years.

DHS continued to contract with IDPH for hawk-i outreach. IDPH continued as the fiscal agent for the Iowa Covering Kids and Families (CKF) State Coalition through funding from the Caring Foundation. Selected CKF project activities were sustained through hawk-i outreach and child health initiatives. Additionally, CKF participated in a non-funded retention initiative, sponsored by the Southern Institute on Children and Families (SICF). Outreach coordinators in the local CH agencies focused their efforts on vulnerable populations, faith-based organizations, primary care providers and schools.

INFRASTRUCTURE BUILDING SERVICES: State staff provided leadership for the following public awareness documents: Issue Brief #13 on Medicaid Continuous Eligibility for Children (Update); Issue Brief #14 on Express Lane Eligibility in Iowa; and Issue Brief #15 on Lawfully Residing Immigrant Children and Health Care Coverage. The briefs can be found at www.idph.state.ia.us/coveringkids/marketing_guide.asp. Staff also developed CKF 2008 Winter Report www.idph.state.ia.us/coveringkids/marketing_guide.asp, and the CKF Electronic Newsletter www.idph.state.ia.us/coveringkids/marketing_guide.asp

CKF, in conjunction with DHS, participated in the SICF sponsored Retention Initiative: Achieving Stability in Medicaid and the State Children's Health Insurance Program (SCHIP) Coverage. The initiative encouraged Medicaid and SCHIP programs to adopt changes in policies & procedures designed to improve retention rates. Iowa's team identified crucial retention issues associated with streamlining the state's Medicaid and hawk-i renewal processes, engaged in Plan-Do-Study-Act small scale testing; and made process improvement recommendations.

CKF continued to provide awareness of health care coverage issues and advance national policy decisions. CKF and DHS applied for the MaxEnroll grant opportunity from the Robert Wood Johnson Foundation but was not selected for funding.

The 2008 Iowa Health Care Reform bill (HF 2539) legislated DHS to collaborate with CKF and other advocates to review issues concerning insuring all children and families. Collaboration resulted in a two day summit aimed at bringing together Iowa advocates and nationally recognized experts in health care reform. The summit resulted in a report titled Maximizing Enrollment and Retention of Children in the Medicaid & hawk-i Programs which was submitted to the Governor and General Assembly.

In 2008, legislators passed the Health Care Reform bill. The intent of this legislation is to provide all uninsured children with hawk-i or Medicaid insurance coverage by January 1, 2011 and to expand the hawk-i program up to 300% FPL. The legislation allows for the implementation of continuous eligibility for Medicaid effective July 1, 2008. The Iowa Choice Health Care Coverage Advisory Council, established through this legislation, submitted a report including recommendations to include a buy-in for the hawk-i program, eliminate the five-year waiting period for legal immigrant children, cover undocumented children, and cover the children of state employees.

POPULATION BASED SERVICES: CKF and hawk-i outreach staff continued to provide outreach materials at statewide conferences representing various target audiences such as: Dental Association, Farm Bureau, education/school based, medical providers, economic development, and diversity conferences. Staff assisted in coordinating the third annual Back-to-School Health Fair and collaborated on Cover the Uninsured Week 2008 activities including convening a town hall meeting, voicing strategies to insure all kids. CKF and hawk-i outreach staff attended daily at Iowa's annual State Fair, talking to families and disseminating materials.

ENABLING SERVICES: Local CH agency hawk-i coordinators worked with families to navigate

the enrollment process and advocate for the family during the eligibility process. hawk-i outreach activities focused on collaboration with free clinics and vulnerable populations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance outreach to special populations.				X
2. Continue to oversee the hawk-i outreach contract with local child health agencies.				X
3. Promote the public awareness campaign on hawk-i.				X
4. Provide technical assistance to local child health agencies.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FFY09, IDPH continues to oversee hawk-i outreach under a contract with the Iowa Department of Human Services. Iowa's CKF project is finishing its work with the Southern Institute on Children and Families' Retention Initiative: Achieving Stability in Medicaid and the State Children's Health Insurance Program (SCHIP) Coverage. Accomplishments include improved data collection and analysis; development of a Medicaid disenrollment survey; enhanced marketing messages on hawk-i renewal reminder postcards; implementation of an electronic signature on online applications and renewals; and policy and procedural improvement recommendations. CKF developed and disseminated the December 2008 Electronic newsletter and is finalizing the 2009 Winter Report.

Outreach continues to target venues including events such as Iowa's Latino Festival, Statewide Asian Festival, and I'll Make Me A World event and tax assistance sites for those who qualify for the Earned Income Tax Credit. CKF and hawk-i outreach staff are planning activities for the 2009 Cover the Uninsured Week campaign. Highlights of this year's campaign include an uninsured simulation where Iowa policy makers spend a day in the life of an uninsured family to see, firsthand, the barriers to accessing health care.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: Due to the lack of dedicated funding, the future of Iowa Covering Kids and Families is uncertain. In FFY10 IDPH will focus on sustainability efforts including collaboration with the following partners: the hawk-i Outreach Taskforce, the Polk County urban-based Healthcare Coverage for Kids Coalition, Iowa's Title V MCH agencies and Iowa's Child and Family Policy Center's Finish Line project. To the degree to which agency capacity is available, key CKF activities will be integrated into existing programs.

Iowa's Medicaid and SCHIP administrators are dedicated to continue work of the Retention Initiative, including efforts to align polices of multiple programs (Medicaid, SCHIP, TANF, FIP, FA) to allow for simplified and streamlined application processes.

POPULATION BASED SERVICES: Outreach will continue across Iowa to educate families and primary care providers about Iowa's health insurance options. Policy changes designed to increase the number of Iowa's children that qualify for the hawk-i program will require enhanced outreach strategies. Local hawk-i Outreach Coordinators will continue to conduct outreach to

health care providers, schools, vulnerable populations and the faith based community. Coordinators will be used as the vehicle to disseminate materials and to assist DHS in educating families about policy changes.

ENABLING SERVICES: Outreach coordinators will continue to help families navigate the Medicaid and hawk-i enrollment and renewal process, requirements of the Deficit Reduction Act, and any other policy changes that have and will occur in the future. Coordinators will identify barriers through the use of occurrence reports and other forms of established communication. The state outreach coordinator and local coordinators will continue to emphasize enrollment with Community Health Centers (CHCs) and free clinics. The majority of CHCs' and free clinic's clients are uninsured and are a target population for outreach efforts.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13	30	30
Annual Indicator		14.0	32.5	32.5	32.6
Numerator		9205	9802	9802	10936
Denominator		65753	30161	30161	33548
Data Source					CDC PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32	30	29	28	27

Notes - 2008
The 2008 data are calculated from the number of children tested times the percent with BMI >85th percentile as reported in CDC PedNSS Reports.

Notes - 2007
PedNSS data for 2007 will not be available until later this year.
Numerators are calculated from the number of children tested x percent with BMI >85th percentile as reported in CDC PedNSS Reports.

Notes - 2006
Data were obtained from WIC clinic clients.

a. Last Year's Accomplishments
The FFY08 Performance Objective of 30 percent was not met. The 2008 PedNSS data show that 32.6 percent of children ages 2 to 5 years, receiving WIC services, have a Body Mass Index (BMI) at or above the 85th percentile.

INFRASTRUCTURE BUILDING SERVICES: Five regional interactive Value Enhanced Nutrition Assessment (VENA) trainings were conducted in the spring of 2008. The Healthy Kids Act was

passed in 2008. The Pick a Better Snack social marketing materials continued to be used and adapted by other states. Five trainings were held for Family Support Staff and these were well attended and well received. A WIC workgroup selected the California Market to Meals materials as the basis for consumer skills instruction for WIC participants. A low fat milk promotional brochure was developed in collaboration with Food Stamp Nutrition Education and is being used in WIC clinics. The Iowans Fit for Life Early Childhood workgroup revised a resource originally produced by the Healthy Polk 2010 for statewide use in promoting breastfeeding friendly worksites.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer regional interactive VENA trainings.				X
2. Implement the strategies in the Healthy Kids Act.				X
3. Promote fruit and vegetable consumption using the Pick a Better Snack social marketing materials in 2008.				X
4. Promote breastfeeding-friendly worksites in the state.				X
5. Provided five trainings for Family Support Staff.				X
6. Provide consumer skills modules to WIC agencies.				X
7. Conduct a low fat milk campaign in WIC.				X
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: The VENA trainings for WIC staff will be institutionalized with a training now being offered annually as one of Iowa WIC's Core Training Workshops. All newly employed dietitians and nurses will be encouraged to take the training. Workgroups met throughout the year to write rules for implementing the Healthy Kids Act. The Healthy Kids Act of 2008 required the Department of Education to revise chapter 58 Administrative code to include nutrition standards for school vending machines and ala carte school lunch. Also, pupils in kindergarten through grade five shall engage in physical activity 30 minutes each day. The Pick a Better Snack social marketing campaign continues to be used throughout the state. The Iowa Lactation Task Force has received the Business Case for Breastfeeding Grant from HRSA. Through this grant, training for 50 people will be offered in the fall of 2009. The objective of the grant is to promote breastfeeding-friendly worksites. Tentative plans are to offer one Nutrition and Physical Activity training for Family Support staff in the spring of 2009. The California Market to Meals campaign materials were printed and mailed to all WIC agencies. A follow-up survey will be conducted to determine if and how they are being used in WIC clinics. WIC agencies are working with participants to transition to lower fat milk in anticipation of the new WIC food package.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: IDPH will continue to: offer VENA Communication skills training; evaluate and promote the trainings with local agency staff; promote the Pick a Better Snack social marketing campaign; offer the Business Case for Breastfeeding trainings; seek out businesses that have adopted breastfeeding friendly practices to serve as models and support for other businesses; offer the Nutrition and Physical Activity Training for Family Support staff annually; evaluate the use of the California Market to Meals campaign and seek other materials promoting planning, preparing and purchasing healthy foods for use in WIC clinics; implement the new WIC Food Package; develop materials for participants that will ease transition to low fat milk, educate participants on purchase and use of fruits and vegetables and whole grain

products; and work with schools and child care centers through the BASICS Program which is funded through the Food Stamp Nutrition Education program.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			17	18	14
Annual Indicator		17.9	18.0	14.9	14.5
Numerator		3265	3284	6075	5846
Denominator		18241	18247	40788	40221
Data Source					Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14	13	12	11	10

Notes - 2008
2008 Data was obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data was obtained from 2007 Vital Statistics provisional data.

Notes - 2006
Data were obtained from the Iowa Barriers to Prenatal Care Survey.

a. Last Year's Accomplishments
The FFY08 objective of 14 percent was not met. Iowa's provisional data for 2008 indicate that percentage of women who smoked in the last three months of pregnancy was 14.5. Women in Iowa continue to smoke at high rates, despite increased taxes on cigarettes and a new law prohibiting smoking in most public places, as well as NRT's being provided to Medicaid eligible women. Many young women are concerned about weight gain and are frustrated with previous attempts to quit that failed and the media is targeting young women.

INFRASTRUCTURE BUILDING SERVICES: Iowa passed a law in the 82nd general assembly banning smoking in most public buildings in Iowa including restaurants and bars.

Staff continue to meet quarterly with a collaborative team that began with the MCHB/AMCHP-sponsored Action Learning Lab. The partnership includes members from ACOG, Planned Parenthood, IDPH Bureaus of Family Health and Tobacco staff. The team is committed to continue to reduce tobacco cessation in women of childbearing age.

ENABLING SERVICES: Training was offered on the tobacco intervention model to local maternal and child health agencies and family planning agencies. Two trainings from staff at Mayo Clinic were offered on motivational interviewing, which is a technique to improve a client's motivation to

change their behavior.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train on the tobacco intervention model to local agencies.		X		X
2. Expand tobacco cessation training to dental hygienists, local I-Smiles coordinators, and WIC staff.		X		X
3. Work with Medicaid leadership to decrease the number of Medicaid women smoking during pregnancy.				X
4. Utilize Iowa PRAMS pilot which will allow a second year of improved data collection.				X
5. Meet monthly with ACOG, Planned Parenthood, AMCHP and tobacco bureau staff.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: Staff are expanding tobacco cessation training for dental hygienists and local I-Smiles coordinators. The training is being offered to WIC staff at the annual statewide conference.

IDPH staff and Iowa Medicaid Enterprise developed a task force to follow up on the Medicaid Match report which indicates that Iowa mothers enrolled in Medicaid are smoking during pregnancy at a higher rate than the national average. The taskforce is exploring strategies to reduce tobacco use in pregnant women. Additionally, analysis of Iowa PRAMS pilot is exploring Iowa women's tobacco usage.

Training was offered on a brief tobacco cessation intervention model was offered at the Bureau of Family Health Fall Seminar on October 7th & 8th in Ames, Iowa. This session was attended by 32 of local MH contract agency staff.

c. Plan for the Coming Year
INFRACTURE BUILDING: IDPH Tobacco Bureau and Title V Maternal Health program will collaborate to address the following tobacco cessation efforts targeting tobacco cessation in women of childbearing age: Implement one statewide media campaign targeting women 18-44 on tobacco cessation efforts, Produce educational materials specific to cessation among women 18-44, Train all 20 Planned Parenthood clinics to implement a brief tobacco intervention, Target women's health clinics through the Tobacco Bureau's Provider Outreach program at the Iowa Tobacco Research center, Encourage women not only to quit smoking during pregnancy (which can result in high relapse rates post partum) but instead quit for life.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	11	10	10	10	9.8
Annual Indicator	10.4	11.0	10.6	10.1	12.9
Numerator	22	23	23	22	28
Denominator	211983	209303	217268	217502	216795
Data Source					Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.7	12.5	12.3	12.1	12

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

a. Last Year's Accomplishments
The FFY08 objective of 9.8 was not met. Iowa's provisional data indicate that the suicide rate for youths aged 15-19 was 12.9 per 100,000. This increase is due in part to a cluster of five suicides in one school district. These suicides, although unconnected, occurred within a short time period. IDPH responded to this district with information and support for parents and school personnel. This district plans to use Columbia TeenScreen with all middle and high school students in the coming year.

INFRASTRUCTURE BUILDING SERVICES: Beginning July 2007, IDPH was awarded $1.2 million for a three-year Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention. IDPH's "Youth Suicide Prevention through Mental Health Screening." The focus is on suicide prevention activities for adolescents ages 15-24. The Columbia Teen Screen is used as the model. It targets youth in high schools for screening, follow-up and treatment. This project also provides support for survivor groups and promotes awareness. An RFP for expansion of Columbia Teen Screen activities in Iowa schools was released in March, 2008. One goal of the RFP is to promote participation in evidence-based mental health and suicide screening and assessment programs for Iowa youth.

POPULATION-BASED SERVICES: IDPH and the Suicide Prevention Steering Committee (SPSC) utilized the Surgeon General's Call to Action to Prevent Suicide and the National Strategy for Suicide Prevention, which highlight the need to increase awareness of suicide as a public health issue and calls for a public health approach focused on suicide prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parents should seek early treatment for children with behavior problems, possible mental disorders and substance abuse problems.			X	
2. Limit young people's access to lethal means of suicide, particularly firearms.				X
3. Encourage health care plans to cover mental health and substance abuse on the level physical illnesses are covered.				X
4. Schools should implement mental health screening programs for children. Teachers should be educated about suicide risk factors and resources to which they may refer children for assistance.				X
5. Children who have attempted suicide or displayed other warning signs should receive aggressive treatment services.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Between May 2008 and May 2009, IDPH funded five community projects to screen youth in schools for mental health problems, referral and follow-up services. Thirty two schools are using the Columbia TeenScreen program and plan to screen over 1,800 youth this year.

The Child Death Review Team is examining records of children whose cause of death was listed as a suicide. Deaths due to suicide or medical conditions may be prevented through timely and appropriate interventions to combat depression, bullying, and disease. Use of firearms was the most frequent means of ending a life. The Centers for Disease Control and Prevention has reported that youth suicides using firearms has decreased nationally over the last few years, while hangings have increased. Iowa followed this trend until 2006, when the trend was reversed.

The Child Death Review Team recommended parent education related to monitoring their child's behavior so that they can tell if the child becomes withdrawn, sullen or exhibits radical changes in behavior. Conferring with school officials to assess modified behavior and address it in a non-threatening, compassionate manner is reinforced.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: Two additional communities will be funded for expansion of the Columbia TeenScreen program. Funding for the current programs will continue.

Coordination of the Child Death Review Team will be transferred from the Bureau of Family Health Title V program to the State Medical Examiner's Office in FFY10.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	80	96	96	96	97
Annual Indicator	95.3	94.7	94.0	94.2	95.0
Numerator	427	463	453	468	420
Denominator	448	489	482	497	442
Data Source					Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	96	97	97	97	97

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

a. Last Year's Accomplishments
The FFY08 annual performance objective of 97 percent was not met. Provisional data for 2008 indicate that 95 percent of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates.

INFRASTRUCTURE BUILDING SERVICES: Birthing centers that wish to change their level status will need to apply to the Perinatal Guidelines committee and show that they meet the criteria to change levels. The addition of Level II Regional Neonatal Centers to our statewide system of regional care will provide increased access to a higher level of care for the very low birth weight infants in Iowa. This is important in rural areas with long travel times to the Level III Perinatal Centers.

POPULATION-BASED SERVICES: During FFY08, publication of the Iowa Perinatal Newsletter continued on a quarterly basis. The 35th Annual Iowa Conference on Perinatal Medicine was held April 9 and 10, 2008 with 270 attendees. Attendees received information on the regional levels of perinatal care and need for appropriate referrals. The S.T.A.B.L.E. Program(c) was offered which includes detailed training in physical assessment of newborns. Improved nursing assessment helps rapidly identify infants that might need referral.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase the number of Level II Regional Neonatal Centers.				X
2. Increase access to a higher level of care for the very low birth weight infants.		X		
3. Publish the Iowa Perinatal Newsletter on a quarterly basis.			X	
4. Strategize with key officials on quality improvement for				X

premature and low birth weight babies on Medicaid.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: IDPH, the Statewide Perinatal Care Program and the Department of Human Services medical director meet on a quarterly basis to discuss quality improvement strategies for premature and low birth weight babies on Medicaid.

ENABLING SERVICES: The Statewide Perinatal Care Team continues its current activities with Iowa birthing hospitals. They are exploring Web-based training, or posting PowerPoint presentations to their Web site to increase their distance learning education strategies.

c. Plan for the Coming Year
INFRACTURE BUILDING: The Perinatal Team will continue to travel to birthing hospitals each year. The number of hospitals in Iowa that provide a birthing service continues to decline. This year the total number is 78. During their site visits, the team will discuss the increased importance of the regionalized system of care in light of decreased total number of hospitals that provide a birthing service. This will result in less hospital visits next year as one Des Moines hospital went from a level II to a level I and one hospital stopped doing deliveries all together.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	88.5	88.6	88.7	87	80
Annual Indicator	88.7	87.2	86.4	77.7	75.9
Numerator	34021	34244	35047	31740	30513
Denominator	38369	39255	40564	40835	40221
Data Source					Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	76	77	78	79	80

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics data.

Notes - 2007

Iowa implemented a revised birth certificate during this reporting period. The questions about entry into prenatal care was changed. Data staff are investigating the accuracy of the reporting. Data were obtained from 2007 Vital Statistics data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

a. Last Year's Accomplishments
The FFY08 annual performance objective of 80 percent was not met. Provisional data from 2008 Vital statistics indicate that 75.9 percent of infants born to pregnant women received prenatal care beginning in the first trimester. There has been a down ward trend in Iowa in early entry into prenatal care. The survey data show the Latinos have the highest rate of entry care late and this population is the fastest growing minority in Iowa. This population experiences barriers to early entry into prenatal care due to lack of insurance as well as to the cultural perception that pregnancy is normal and prenatal care is not needed.

INFRASTRUCTURE BUILDING SERVICES: Local maternal health contract agencies identify strategies for coordinating with other community programs. Fourteen of the local contract agencies have implemented an action plan targeting prenatal care for women in their community. Many are conducting surveys of women who entered prenatal care late to determine what barriers the women had, if any. Barriers data show a slight increase in the travel time to prenatal care providers.

POPULATION-BASED SERVICES, ENABLING SERVICES, AND DIRECT HEALTH CARE SERVICES: Direct health care, enabling, and population-based program activities are provided by 24 MH contract agencies serving all 99 counties. MH agencies provide services to facilitate early entry into prenatal care including Medicaid presumptive eligibility determination, care coordination, case management including follow-up, and case-finding and outreach with a focus on high-risk women. IDPH also works with DHS to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase outreach presentations to churches, schools, and community centers.		X		
2. Promote communication and collaboration among local maternal health agencies and other local agencies.				X
3. Integrate maternal health services with WIC, child health programs, family planning services, and DHS programs.				X
4. Target vulnerable populations.				X
5. Advocate for improved access for undocumented (immigrant) women.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: Vital records, the Women's Health Information System and the surveys of women who did not receive early care were used by local agencies to determine the population in need of specific efforts. IDPH staff support collaboration between and

among state and local agencies. Integration of MH services with WIC, CH programs, FP services and DHS programs continues. IDPH staff support and monitor local contract agencies' vulnerable population action plans and advocate for improved access to early prenatal care for undocumented (immigrant) women. All local contract agencies are implementing action plans for early prenatal care targeting vulnerable populations in their communities.

The number of agencies who offer free pregnancy tests has doubled and is expected to increase early identification of adolescent pregnancies. School nurses are informed which agencies provide free pregnancy testing. Local MH agencies can now bill for completing the application for presumptive Medicaid eligibility determination.

ENABLING SERVICES: Local MH contract agencies provide presumptive eligibility to pregnant women. 14 local contract agencies are committed to increasing the number of women who receive early entry prenatal care. Activities include: a public awareness campaign; outreach presentations to churches, schools and community centers; and flyer distribution to pregnant women. WIC and MCH staff provide follow-up encouraging education on early prenatal care.

c. Plan for the Coming Year

INFASTRACTURE BUILDING SERVICES: Fourteen local contact agencies plan to continue surveys of women who entered prenatal care late. They plan to use the data to continue to identify local barriers for accessing prenatal care. The survey data indicate that Blacks and Latinos entry into care later than Whites. Surveys also show they delayed care due to denial of the pregnancy, were afraid to tell their parents, had no insurance, just move to Iowa so did not know were to go, and had transportation issues.

ENABLING SERVICES: Three agencies are planning specific activities for Hispanic women in their community. Surveys have shown there is a need for education on the importance of prenatal care in this population. Collaboration with Family Planning agencies and other agencies that do pregnancy testing to increase early referrals and outreach is also ongoing.

D. State Performance Measures

State Performance Measure 1: *Percent of children served by family support programs, whose primary delivery method is a home visit, that are served through evidence-based programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	55	60
Annual Indicator		19.0	22.9	22.9	18.8
Numerator		11	6815	6815	6634
Denominator		58	29756	29756	35254
Data Source					family support programs scan
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	22	24	25	27

Notes - 2008

2008 Data were obtained from an environmental scan of family support programs funded through the EC system

Notes - 2007
Data were obtained from an environmental scan conducted in February of 2007 with family support programs whose primary delivery method is a home visit. The peformance measure data set was change to show the most recent data on family support. The environmental scan will be updated every two years.

Notes - 2006
Data were obtained from an environmental scan conducted with family support programs whose primary delivery method is a home visit. The peformance measure data set was change to show the most recent data on family support.

a. Last Year's Accomplishments
The FFY08 performance objective of 60 percent was not met. An environmental scan of family support programs funded by Iowa's Early Care, Health, and Education system and the number of children served; indicate 6,634 out of 35,254 children were served by evidence-based programs, which is 19 percent. The decrease in the indicator is likely attributable to an influx of new programs that do not utilize evidence-based approaches. Iowa is working on improving the quality of family support programs through the implementation of the Iowa's Family Support Credential. The Credential process is in the first year and will take a few years to see an increase in the number of programs in quality programs.

INFRASTRUCTURE BUILDING SERVICES Through the Early Childhood Comprehensive Systems Project, Early Childhood Iowa Quality Services and Programs (QSP) component group has addressed the quality of family support and parent education and provided tools and technical assistance to local programs. The Family Support Leadership group met twice to provide strategies and advice for family support and parent education. The Family Support Coordinator with the Office of Empowerment serves as the lead staff person for the family support projects workgroups.

Iowa's Family Support Credentialing process continued to gain support at the state and local level. A Family Support Credentialing workgroup that includes sub workgroups oversaw the process along with the Family Support Leadership group. Based on three Family Support Peer Reviews pilots conducted in 2007, the Family Support Credentialing process was reworked and rolled out in January of 2008. By the end of FFY08, over 30 programs were accepted. Through the Peer Review and Credentialing Process reviewers were selected and trained and a Family Support Technical Assistance Team was trained to begin work with the participating local family support programs.

The Family Support Leadership group (FSLG) workgroup met regularly to address Standards and Core Competencies and the Outcomes and Credentialing Process. The workgroups included members beyond the network of the core FSLG. Family organizations are represented on the FSLG.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide technical assistance and promote evidence-based family support programs.				X
2. Through Early Childhood Iowa, continue to convene the Family Support Leadership group.				X
3. Promote Iowa's Family Support Credentialing process.				X

4. Provide technical assistance on the family support standards.				X
5. Finalize the family support core competencies.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: Fifty-eight (58) programs completed the Family Support Credentialing application and were accepted into the credentialing process. A waiting lists exists due to limited funding.

The University of Iowa, National Resource Center for Family Centered Services developed a curriculum for a certification program for family support supervisors. The curriculum is being piloted with 25 FS supervisors. The University of Iowa also developed core competencies for family support workers and family support supervisors as a critical step in the curriculum development. The core competencies will be available July 1, 2009. The Outcome workgroup developed a core set of indicators for all family support and parent education programs. Trainings on standardized data collection were conducted. ECI is developing a comprehensive early childhood professional development system for early care and education, health and family support professionals. A workgroup comprised of representatives from all family support program models convened to develop a systematic approach to professional development for family support. Work is in progress to; 1) outline the professional development needs required by the program model, and 2) outline best practice recommendations for family support workers. The plan is cross-reference with the Iowa Family Support Standards and will be available in summer 2009.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES The Family Support Leadership workgroups continues to meet and advance strategies. The Peer Review and Credentialing Process will provide technical assistance to local family support programs engaged in the credentialing process. The Family Support Coordinator will continue to work with local providers to improve the program.

The Family Support Leadership group will explore the development of a Parent Leadership group. The Leadership group will address key strategies such as the development of parent leadership and improving effective strategies on receiving and getting input from parents. ECI is researching parent council/leadership groups in other states and will make recommendations on best practices to te Family Support Leadership Group and the Early Childhood Iowa Council.

Quality Services and Programs members will continue to advocate for Iowa Family Support Credentialing process funding to reduce the waiting list. Family Support Supervisor training will be available statewide through the University of Iowa by the Fall 2009.

State Performance Measure 2: *Percent of early care and education businesses who have received a training or service from a child care nurse consultant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			1224	1750	35

Annual Indicator		1182	1717	29.7	39.6
Numerator				2280	3045
Denominator				7688	7688
Data Source					NCCIC Iowa profile
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	42	45	50	52

Notes - 2008
2008 Data collected from the National Child Care Information Center, State profile for Iowa: Total Number Licensed/Regulated FCCG added to the Number of Licensed Child Care Centers. The objective changed in 2007 from the number businesses that have received training to a percentage of businesses.

Notes - 2007
Data were obtained from the Healthy Child Care Iowa encounter data and the National Child Care Information and Technical Assistance Center.

Notes - 2006
Data were obtained from the Heathly Child Care Iowa Child Care Nurse Consultant log.

a. Last Year's Accomplishments
The FFY08 performance objective indicator 39.5 percent exceeds the 35 percent target. Data from the National Child Care Information Center, state profile for Iowa shows 39.6 percent of early care and education businesses received training or service from a child care nurse consultant children. In 2007, the performance measure was changed from number of encounters to the percentage of early care and education businesses to who child care nurse consultant provided a service.

INFRASTRUCTURE BUILDING SERVICES: Activities from FFY08 included two training sessions conducted for child care nurse consultation using the National Training Institute (NTI) curriculum, six Universal Precautions and Exposure Control Plan (UP/ECP) and Mandatory Child Abuse Reporter Training (MART) distance learning sessions. Three professional development distance learning sessions were held addressing pesticide use in child care, new federal guidelines for the Child and Adult Care Food Program, and a session about infant and toddler play-spaces. CCNC encounter data collection method options were explored to include online data reporting, beginning July 2008.

POPULATION-BASED SERVICES: HCCI expanded the Web site to include health and safety resource materials for Iowa child care directors enrolled in the National Administrator Credential training.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to serve on the Quality Rating System oversight team.				X
2. Provide technical assistance training to child care nurse consultants.				X
3. Continue to advocate for sustained child care nurse consultant funding.				X
4. Continue the operations of the HCCI talkline and Web site.		X		

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Current activities include three sessions of the Iowa Training Project for Child Care Nurse Consultants (ITPCCNC), using online methods to collect CCNCs encounter data and collaborating with key stakeholders in writing a white paper regarding CCNC services.

POPULATION-BASED SERVICES: Current activities include offering professional development opportunities for early childhood care and education providers through two distance learning presentations of Universal Precautions/Exposure Control Plan (UP/ECP) and Mandatory Child Abuse Reporter Training. HCCI is collaborating with the University of Iowa's Learning Management System to place the UP/ECP training online for early child care and education providers. HCCI is also offering professional development related to the Iowa Fire Code for Child Care Centers in compliance with the American's with Disabilities Act.

c. Plan for the Coming Year

HCCI will complete system-level evaluation of the CCNC network. Professional development strategies include placing courses on the Learning Management System for the UP/ECP and MART (courses for child care businesses). ITP/CCNC will be expanded to include competency skill assessment to determine successful completion of the course. HCCI will also develop and offer professional development on fire prevention safety for child development home providers and explore electronic methods for improving communication among CCNCs.

State Performance Measure 3: *Percent of Medicaid enrolled children zero to five years who receive developmental evaluations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			7	10	12
Annual Indicator		8.2	4.4	4.1	2.3
Numerator		7004	3842	3624	2142
Denominator		85386	87979	89419	92966
Data Source					CMS 4.16 report
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	4	5	8	10

Notes - 2008

The 2008 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

a. Last Year's Accomplishments
The FFY08 performance measure of 12% was not met. Data from the CMS 4.16 Annual EPSDT Participation Report show that the Percent of Medicaid enrolled children ages 0 to 5 who received developmental evaluations was 2.3%. Two contributing factors are notable. First, an error in previously reported 4.16 data was identified. Second, 1st Five projects (the primary strategy) focused on implementing surveillance rather than advancing the use of standardized developmental screening tools billable to Medicaid. In spite of focused community interventions and project evaluation data that suggest substantial progress was made, the focus on surveillance and continued lack of awareness among primary care providers regarding Medicaid reimbursement resulted in the annual decrease in the indicator.

INFRASTRUCTURE BUILDING SERVICES: IDPH continued to implement strategies designed to improve services that support healthy mental development with a focus on children age 0 to 5. IDPH added an additional implementation site that includes two counties and three planning sites that serve five counties. During SFY08, 39 medical practices were engaged in 1st Five identification, referral and follow-up which served approximately 41,000 children age 0 to 5.

Limited progress was made on Web page development. Strategies to promote awareness focused on presentations to health care professionals, partnering with early childhood providers and policy makers. The 1st Five Executive Summary was developed and distributed to primary care providers and practices throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to local 1st Five projects.				X
2. Develop a public awareness campaign on the importance of developmental screening and surveillance.				X
3. Collect and evaluate data on screenings, referrals, and follow-up from pilot projects.				X
4. Continue to work with Early Childhood Iowa, Iowa Medical Home initiative, and Iowa's perinatal depression project.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES: The 1st Five Healthy Mental Development coordinator position was vacant most of FY09 due to a state hiring freeze. Plans are in place to fill the position part time (0.5 FTE) through an inter-agency agreement with the Department of Management/Office of Community Empowerment. The agreement is effective July 1, 2009. Although the 1st Five project has lacked a statewide coordinator for much of the year, IDPH continues to spread 1st Five strategies with additional implementation sites and community planning grants. 1st Five collaborated with Early ACCESS to provide Enhancing Developmentally Oriented Primary Care (EDOPC) project training for primary care providers and Title V contract agencies. The training focuses on implementing the ASQ and ASQ:SE developmental screening tools. A train-the-trainer program is currently in progress with 35 trainers across the state.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES: Implementation project funding is available to the three 1st Five planning sites for a three-year project period. Sustainability project funding is available to the sites that complete the three-year implementation project. Funding is contingent on successful applications submitted through a competitive bid process, and the additional implementation site will enter its third year of funding. Initiation of new planning project opportunities is contingent on available funding.

Through continuing partnership with Early ACCESS, ASQ and ASQ:SE in English and Spanish will be made available to each of the 23 local CH contract agencies. Regional trainings will be conducted throughout the state through the train the trainer program developed with the support of the Illinois-based EDOPC. Plans include content on billable services related to screening and follow-up in an attempt to improve the reliability of claims data for the Medicaid population. Additional strategies include fostering collaboration with the University of Iowa based Professional Development Initiative, building partnerships with primary care provider networks, seeking additional technical assistance from EDOPC, improving referral and follow-up protocols, and enhancing care coordination. Additionally, the project will disseminate "lessons learned" to local CH agencies through Title V MCH grantee meetings.

State Performance Measure 4: *Percent of children who needed care from a specialist who received the care without problem.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			87	88	89
Annual Indicator	83.7	83.7	85.1	85.1	85.1
Numerator	101929	101929	113046	113046	113046
Denominator	121842	121842	132839	132839	132839
Data Source					2005 Child and Family Household Health Survey
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	91	92	93	94

Notes - 2008
Although our data source for this SPM (the Iowa Child and Family Household Health Survey) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve families' ease of access to specialty care.

We are now engaged in plans to implement the third administration of the Iowa Child and Family Household Health Survey in 2010. If a continuing state priority, new data for this annual performance indicator should be available for the 2010 reporting year.

Notes - 2007
Although our data source for this SPM (the Iowa Child and Family Household Health Survey) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve families' ease of access to specialty care.

Notes - 2006
The 2006 annual indicator value was calculated from data collected in the "2005 Iowa Child & Family Household Health Survey" - a random sample phone survey supplemented with some convenience sampling.

a. Last Year's Accomplishments
The FFY08 performance objective of 89.0 percent was not met based on results of the population-based 2005 Iowa Child and Family Household Health Survey. The indicator value derived from the survey was 85.1 percent. CHSC has set a higher target objective to motivate continuous performance improvement.

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, CHSC staff served on the advisory group for Iowa's safety net provider collaborative network, one goal of which is to improve access to specialty services for safety net users.

CHSC participated in the 3rd annual statewide conference on Early Childhood Comprehensive Systems goals for early childhood health care services and formulated policies to assure access to needed specialty health and dental services for young children.

Under SAMHSA support, CHSC and the Iowa Department of Human Services collaborated with other community agencies to continue developing a System of Care to improve access to and quality of mental health services for children and youth with severe emotional disorder.

DIRECT AND ENABLING SERVICES:

The CHSC telehealth behavioral consultation program continued to provide telehealth and telepsychiatry consultations to children from geographically remote regions of Iowa who are without access to specialty care.

A CHSC nutrition consultation service was reformulated to assure that nutrition-related issues of children with special health care needs could be effectively and promptly clinically addressed.

CHSC's Early Hearing Detection and Intervention project used family participation staff to assist families adapt to and understand the special needs and services newly associated with their child's hearing loss.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC co-leads a SAMHSA-supported System of Care project to improve access to quality mental health specialty services for children with severe emotional disorder.				X
2. CHSC partners with the Iowa-Nebraska Primary Care Association to offer Iowa safety net providers medical home-related technical assistance, including improving access to needed specialty care.				X
3. CHSC collaborates with the Iowa Dept of Public Health's 1st Five project to assure referrals to needed specialty services for young children who are developmentally at-risk or delayed.				X
4. CHSC leads an MCHB-supported Early Hearing Detection and Intervention project to improve access to specialty hearing services for children identified with or as at-risk for hearing				X

problems.				
5. CHSC provides facility support to the Univ of Iowa's Continuity of Care Program, which assures and coordinates access to community-based specialty care for seriously ill children.	X	X		
6. CHSC's Health & Disease Management unit provides assistance accessing community-based and medical center-based specialty services for Medicaid waiver enrollees.		X		
7. CHSC continues telehealth technology and consultation services to meet gaps in access to pediatric medical and behavioral health services.	X			
8.				
9.				
10.				

b. Current Activities
INFRASTRUCTURE BUILDING SERVICES:

In FFY09, CHSC co-leads a SAMHSA-supported System of Care project to improve access to quality mental health specialty services for children with severe emotional disorder.

CHSC partners with the Iowa-Nebraska Primary Care Association to offer Iowa safety net providers medical home-related technical assistance, including improving access to needed specialty care.

CHSC collaborates with the Iowa Dept of Public Health's 1st Five project to assure referrals to needed specialty services for young children who are developmentally at-risk or delayed.

CHSC leads an MCHB-supported Early Hearing Detection and Intervention project to improve access to specialty hearing services for children identified with or as at-risk for hearing problems.

DIRECT AND ENABLING SERVICES:

CHSC provides facility support to the Univ of Iowa's Continuity of Care Program, which assures and coordinates access to community-based specialty care for seriously ill children.

CHSC's Health & Disease Management unit provides assistance accessing community-based and medical center-based specialty services for Medicaid waiver enrollees.

CHSC continues telehealth technology and consultation services to meet gaps in access to pediatric medical and behavioral health services.

c. Plan for the Coming Year
INFRASTRUCTURE BUILDING SERVICES:

In FFY10, CHSC will continue to co-lead a SAMHSA-supported System of Care project to improve access to and quality of mental health specialty services for children and youth with severe emotional disorder.

CHSC will take the initial lead in creating a Family-to-Family Health Information Center that will empower families to more effectively find and participate in their children's specialty services.

CHSC will, if approved, participate in a new Commonwealth Fund-supported project to improve linkages between primary care providers and community-based early intervention specialty services for young children who are developmentally at-risk or delayed.

CHSC will continue to lead an MCHB-supported Early Hearing Detection and Intervention project to improve access to specialty hearing services for children identified with or as at-risk for hearing problems.

CHSC will review "access to specialty services" data elements from the National Children with Special Health Care Needs Survey and the Iowa Child and Family Household Health Survey for use in the upcoming Title V needs assessment.

CHSC will advocate incorporating assessment of social determinants of health in any provider care plans for children needing specialty services.

DIRECT AND ENABLING SERVICES:

CHSC will continue facility support for the Univ of Iowa's Continuity of Care Program, which assures and coordinates access to community-based specialty care for seriously ill children.

CHSC's Health & Disease Management unit will continue providing assistance accessing community-based and medical center-based specialty services for Medicaid waiver enrollees.

CHSC will continue telehealth technology and consultation services to meet gaps in access to pediatric medical and behavioral health services.

State Performance Measure 5: *Percent of children 0-3 years served by Early ACCESS (IDEA, Part C).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			2.4	2.8	2.9
Annual Indicator	2.1	2.3	2.7	2.7	3.0
Numerator	2331	2581	2932	3185	3576
Denominator	110276	110650	108593	116411	118296
Data Source					IDEA, Part C Early ACCESS IMS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	3.1	3.2	3.3	3.4

Notes - 2008
2008 Data were obtained from the IDEA, Part C -Early ACCESS Information Management Systems data. Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

Notes - 2007
Data were obtained from the IDEA, Part C - Early ACCESS Information Management Systems data.

Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate

target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

Notes - 2006
Data were obtained from the IDEA, Part C - Early ACCESS Information Management Systems data.

Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

a. Last Year's Accomplishments
The FFY08 performance objective of 2.8 percent was met. The FFY08 indicator value was 3 percent according to data from the Early ACCESS (IDEA, Part C) database. Although Iowa currently meets the OSEP recommendations for percentage of the 0 to 3 population enrolled in Part C (2.0 percent), there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have set progressively higher annual performance target objectives.

INFRASTRUCTURE BUILDING SERVICES: In FFY08, CHSC and the Iowa Department of Public Health (IDPH) continued collaboration with Iowa's Part C Program to improve access and services to children who have or are at-risk for developmental delay. Both CHSC and IDPH identified specific populations of children for whom they provide selected Early ACCESS services. Target populations were identified based on the child heath service providers' scope of practice.

DIRECT AND ENABLING SERVICES: Local CH agencies provided service coordination and developmental evaluation and assessment for the target population of lead poisoned children. Within IDPH, MCH and Environmental Health partnered to offer expanded comprehensive services to lead poisoned, Early ACCESS eligible children. Lead Program case managers worked with local MCH agency to make referrals for Early ACCESS developmental evaluation and assessment. CHSC service coordinators targeted three primary populations: children born prematurely, medically complex and drug-exposed. CHSC Clinical Program health providers were a referral source and provided health information and health outcomes to children on IFSPs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide IDEA Part C service coordination at all CHSC regional centers for children who are medically complex; drug-exposed; or born prematurely.		X		
2. Provide nutrition consultation services statewide for children enrolled in IDEA Part C.	X			
3. Partner with IDEA Part C and IDPH 1st Five to improve the performance of primary care providers regarding early childhood developmental screening and referral for early intervention.				X
4. Expand the Regional Autism Services Program to screen all CHSC clinic patients 18-36 mos. for autism and assure regional autism teams train local staff to appropriately identify children with autism condition.				X
5. Continue the Early Hearing Detection Intervention (EHDI) project to improve the system of early identification and referral for children with hearing problems.				X

6. Deliver statewide training on an evidence-based screening tool to increase the quality of Part C referrals and reduce the gap between those served by Part C and those who are eligible and benefit from services but are not referred to Part C.				X
7.				
8.				
9.				
10.				

b. Current Activities

In FFY09, CHSC and local CH contract agencies continue to refer to Early ACCESS and provide services to targeted populations of children. Early ACCESS continued to contract with CHSC's Iowa Medical Home Initiative to improve the performance of primary care physicians regarding early identification, referrals, promotion of developmental screening, and early intervention services by primary care practices.

The Regional Autism Services Program (RASP), based at CHSC and funded by the Department of Education, assures that regional autism teams train local staff to appropriately identify children with learning or behavioral needs associated with autism spectrum disorders diagnoses.

DIRECT AND ENABLING SERVICES: CHSC provides Early ACCESS service coordination at 11 regional centers to three target populations of children. CHSC provides Part C nutrition services statewide by connecting to three registered dietitians using polycom technology. The RASP expanded screening for autism to include all toddlers entering CHSC between the ages of 18 and 36 months. Local CH agencies provided service coordination and developmental monitoring for selected populations.

The Early Hearing Detection Intervention (EHDI) project continued to improve Iowa's EHDI surveillance system to appropriately identify children. IDPH and CHSC provided statewide training for providers on the PEACH (Parent Nutrition/Feeding Questionnaire) and vision screening tools.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: In FFY10, IDPH and CHSC will continue partnering with the interagency Early ACCESS System to assure that young children are identified and appropriately served according to designated procedures and standards.

New CHSC and local Title V contract agency service coordinators will be trained in the delivery of the DAYC Evaluation tool.

IDPH and CHSC staff will provide leadership for a state wide initiative to train early care health and education providers on an evidence-based screening tool to increase the quality of Early ACCESS referrals.

CHSC participates as a stakeholder in Iowa's Early Childhood Comprehensive Systems effort (Early Childhood Iowa) via participation on the Results Accountability and Quality Services and Programs subcommittees.

IDPH staff will assist with the development and implementation of an electronic Individualized Family Services Plan (IFSP). CHSC will monitor and evaluate the effectiveness of autism screening of all children age 0-3 seen in CHSC clinics and will continue providing staff development to Early ACCESS staff and early care providers regarding strategies to treat food refusal in children with autism spectrum disorders.

The EHDI project will begin activities scheduled for year one of the new three year grant. Audiologists and EHDI program staff will provide intensive technical assistance to hospitals with high miss and referral rates. The EHDI project will also participate in the National Initiative for Children's Healthcare Quality, focusing on reducing the lost to follow-up rate.

DIRECT AND ENABLING SERVICES: The EHDI project will focus on increasing the percentage of children getting the follow-up hearing services and educating families and professionals about the importance of screening and diagnosis. Family support organizations will be connected to each other and the Guide By Your Side family support program will be continued.

CHSC nutritionists will be available to assist Early ACCESS staff to: 1) administer a nutrition and feeding questionnaire to identify nutrition risks in 0-3 year olds; and 2) use referral guidelines to access nutrition services for children at risk.

State Performance Measure 6: *Percent of Iowa counties that have at least one participating targeted community in the CDC nutrition and physical activity obesity prevention project.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			15	18	24
Annual Indicator		12.1	18.2	12.1	36.4
Numerator		12	18	12	36
Denominator		99	99	99	99
Data Source					Iowans Fit for Life
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	38	40	45	48	50

Notes - 2008
2008 Data were obtained from the IDPH – Iowans Fit for Life Project.

Notes - 2007
Data were obtained from the IDPH - Fit for Life Project.

Notes - 2006
Data were obtained from the IDPH - Fit for Life Project.

a. Last Year's Accomplishments
Provisional data from the Iowans Fit for Life Project show that 36 counties in Iowa (36.4 percent) that have at least one participating targeted community in the nutrition and physical activity obesity prevention project. The pilot intervention community coalitions were in place with expanded access to fruits, vegetables and physical activity opportunities in their communities. The curriculum established in FFY06 continues to be used in schools. Data were collected (BMI, physical activity surveys, nutrition surveys, and parental surveys) and analyzed. Teacher feedback was collected to look at how the intervention may need to be modified for future years.

POPULATION-BASED SERVICES: A cross-disciplinary curriculum was established for use in the intervention schools. The curriculum focuses on fruits, vegetables and physical activity and provides opportunities for both fruit and vegetable tasting and physical activity. The Pick a Better Snack and ACT social marketing campaign was also implemented in the schools.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support Iowans Fit for Life stakeholder group and workgroups.				X
2. Provide technical assistance to local targeted communities working on nutrition and physical activity.			X	X
3. Continue to conduct assessments with third, fourth, and fifth graders on nutrition and physical activity.	X		X	
4. Implement the recommendations of the Healthy Children's Task Force.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: The data collection process is being repeated using the same methods referenced above, using third, fourth and fifth graders for the assessment. Community coalition and the physical activity interventions continue. The school intervention including the cross-disciplinary curriculum continues as well. In addition, program sustainability will be monitored in the original programming groups. A school and community toolkit is being developed so that the intervention can be expanded during 2009.

The Iowans Fit for Life Partnership continues, including the early childhood and the educational settings work group. The early childhood work group completed regional nutrition and physical activity trainings for family support workers.

Eleven local MCH contract agencies identified action plans to reduce occurrence of childhood obesity. The activities in the action plans include staff collaboration to determine methods of addressing childhood weight, providing healthy eating/physical activity materials in English and Spanish, and working with local school districts to address healthy eating and physical activity.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: The pilot intervention in the current 12 communities will be ending. A school and community toolkit will used to expand the intervention into six new communities. The 24 community wellness grants will continue their project for another year. New community wellness grants will also be distributed with state and federal funding. The Iowans Fit for Life Partnership will continue including the early childhood and educational settings work group.

State Performance Measure 7: *Percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			60	68	68
Annual Indicator		57.5	67.2	61.4	68.5

Numerator		11768	12251	13281	15532
Denominator		20474	18242	21620	22682
Data Source					STELLAR and Medicaid data match
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	70	70	70	70

Notes - 2008
2008 Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

Notes - 2007
Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

Notes - 2006
Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

a. Last Year's Accomplishments
The FFY08 performance objective of 68 percent of Medicaid enrolled children receiving a lead test was met. Overall, 68.5 percent of Medicaid children received a blood lead test.

INFRASTRUCTURE BUILDING SERVICES:
The IDPH Bureau of Family Health (BFH) worked closely with the IDPH Bureau of Lead Poisoning Prevention to monitor statewide data for children receiving blood lead tests. The Bureau of Lead Poisoning Prevention conducted a data match with Medicaid enrolled children who are in STELLAR (Systemic Tracking of Elevated Lead Levels and Remediation). Data reflecting the percent of children ages 9-35 months receiving a blood lead test were shared with each local CH contract agency. The data included testing percentages for both Medicaid and non-Medicaid children for each agency's service area. The indicator for SPM #7 was included as a key data element on the FFY08 Year End Report for local CH contract agencies. This allows for annual tracking at the local level.

EPSDT program training was offered to all local CH contract agencies. Training emphasized blood lead testing as an important component of comprehensive health screening for all Iowa's children according to the Iowa Recommendations for Scheduling Care for Kids Screenings. At a statewide seminar, a round table presentation included key indicators including statewide and local level activities that address blood lead testing.

The 2007 Iowa General Assembly passed legislation requiring evidence of a blood lead test upon a child's enrollment into school by the age of six. In FY08 the IDPH and the Department of Education (DE) worked together to lay groundwork for implementation of these requirements. The legislation has focused media attention on the issue. Press conferences and articles in a variety of newspapers across the state featured the legislation and the importance of blood lead testing. IDPH continues emphasis on early blood lead testing according to EPSDT guidelines (ages 12 and 24 months and if high risk, also at 18 months, 3, 4, and 5 years).

State level policy establishes eligibility for Early ACCESS (IDEA, Part C) based upon a child's blood lead level. Any child who has venous blood lead levels equal to or greater than 20 µg/dL is eligible for Early ACCESS services. Local CH contract agencies provided service coordination for children who meet this criterion. Trainings were provided for CH contract agencies to address the effects of childhood lead poisoning and the importance of early testing, monitoring, and referral for children with elevated blood lead levels. Trainings also addressed the IDEA law and state Early ACCESS policies and procedures.

POPULATION-BASED SERVICES: Contractors provided access to blood lead testing by coordinating care through a child's medical home or providing the gap-filling service. Many child health contractors arranged for blood lead testing in conjunction with other programs such as WIC, immunizations, preschool, child care, Head Start and Early Head Start.

During FFY08 an increase was noted in the number of CH contract agencies using the Lead Care II, a CLIA waived blood lead analyzer which conducts blood lead analysis on-site for capillary draws. IDPH provided guidance on reporting requirements for test results. The Iowa Medicaid Enterprise provides reimbursement for both blood lead draws and blood lead analysis for Medicaid enrolled children.

Six local CH contract agencies identified increasing blood lead testing rates as a priority for action plans. Activities for FFY08 included data collection and analysis; enhanced outreach initiatives; conducting blood lead tests and/or analysis; coordination of care and follow-up; public education efforts; presentations to local boards of health; coalition building; and working with local providers to promote blood lead testing. During FY 2008, referrals continued to child health contract agencies for Early ACCESS service coordination for children with venous blood lead levels equal to or greater than 20 µg/dL.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor the state level data for blood lead levels.				X
2. Work with local school districts and public health entities to implement the required lead screening prior to school entry.			X	X
3. Provide technical assistance to local MCH, WIC, and Public Health agencies to promote access to blood lead testing.				X
4. Promote health education/media awareness to advance age-appropriate screening.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: BFH continues to work closely with the Bureau of Lead Poisoning Prevention to monitor statewide data for children receiving blood lead tests. Relevant data for the 2005 birth cohort is provided to local CH contract agencies. CH contract agencies continue to monitor and report the performance indicator for the percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test in their service area. IDPH continues to provide training and technical assistance pertaining to blood lead testing.

The IDPH and the DE continue to work together to assist local school districts and public health agencies in their efforts to implement the mandatory requirement for blood lead testing prior to school entry. School districts submit names of kindergarten enrollees who are then matched to the STELLAR database. Children who have not received a blood lead test are referred for testing.

POPULATION-BASED SERVICES: The Bureau of Lead Poisoning Prevention's public service announcements and county-specific brochures promoting blood lead testing are shared with local

Childhood Lead Poisoning Prevention Programs and public health agencies. Local CH contract agencies continue to provide service coordination under Early ACCESS for children who have venous blood lead levels equal to or greater than 20 µg/dL.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: EPSDT training for staff from CH contract agencies will continue to emphasize the importance of blood lead testing for all children according to the Iowa Recommendations for Scheduling Care for Kids Screenings.

The Bureaus of Family Health and Lead Poisoning Prevention will continue to monitor statewide data for children receiving blood lead tests. CH contract agencies will continue to monitor and report the performance indicator for the percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test in their local service area.

The Centers for Disease Control and Prevention (CDC) is working on development of a new, Web-based data system for tracking blood lead test results. Implementation of the data system would improve the quality of the data transmitted to IDPH and improve the timeliness of data receipt and reporting. Upon implementation, training and access to the system will be provided to local CH contract agencies.

Opportunities for additional training and education will be explored for the Bureau of Family Health's Fall Seminar and the University of Iowa's Annual School Nurse Conference.

POPULATION-BASED SERVICES: Local CH contract agencies will continue to promote blood lead testing and provide appropriate care coordination and follow-up services.

Contract agency staff will continue to provide service coordination under the Early ACCESS program for children who have venous blood lead levels equal to or greater than 20 µg/dL. Service coordinators will complete a Lead Orientation developed by the Bureau of Lead Poisoning Prevention. The statewide referral system for developmental evaluation and monitoring between local lead programs and Early ACCESS coordinators will continue.

The Bureau of Family Health will promote the use of media resources among local CH contract agencies to encourage childhood blood lead testing. The Bureau of Lead Poisoning Prevention's public service announcements and county-specific brochures will be shared with CH contract agencies.

State Performance Measure 8: *Percent of Medicaid enrolled children ages 1-5 years who receive dental services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			38	38	40
Annual Indicator		37.0	38.4	42.1	45.2
Numerator		27646	29413	32808	36642
Denominator		74672	76637	77889	81033
Data Source					CMS 416 report
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	47	49	50	51	52

Notes - 2008
2008 Data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2007
The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2006
The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

a. Last Year's Accomplishments
The FFY08 performance objective of 40 percent was met. The 2008 CMS report shows 45.2 percent of children ages 1 to 5 who are enrolled in Medicaid received a dental service.

INFRASTRUCTURE BUILDING SERVICES: In FFY07, the IDPH Oral Health Bureau submitted a request to Department of Human Services to recognize oral screenings as part of the dental EPSDT periodicity schedule. The revised periodicity schedule also includes a minimum of one exam by a dentist each year. The impetus for the request was the I-Smile initiative, which uses risk assessment and trained health care providers to screen children, thus allowing a broader network for fulfilling periodicity guidelines. DHS requested that OHB seek endorsement for the periodicity schedule changes from the Iowa Chapter of the American Association of Pediatric Dentistry. The public health dental director approached AAPD, however has not yet received their endorsement.

Due to the continuing dental access issues, DHS approved several new dental service codes for use by local MCH agencies. New services include nutritional counseling and tobacco counseling specific to the prevention of oral disease. OHB worked with DHS to create protocols, including the ability of non-dental health care professionals to provide billable services.

POPULATION-BASED SERVICES AND ENABLING SERVICES: Through support from the State Oral Health Collaborative Systems, OHB created and printed I-Smile Screening Guides for Health Care Professionals. OHB created guides that provide basic information on how to conduct an oral screening and apply fluoride varnish for children ages 0 to 3, in addition to some basic oral health education information that can be shared with parents.

A Targeted Oral Health Service Systems grant from HRSA is being used to promote I-Smile and the importance of early, regular care for children beginning at age one, as well as to create an oral health surveillance system for early childhood. During this initial year, OHB conducted assessments to determine health promotion needs of Iowa families. This included assistance from Iowa's Center on Health Disparities to assess needs of our ethnic, minority, immigrant and refugee populations.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote the I-Smiles project at the state and local level.				X
2. Provide technical assistance to local I-Smiles coordinators on infrastructure building activities.				X
3. Continue to promote a public awareness campaign on the importance of dental homes.				X
4. Implement physicians' trainings on oral health and early childhood in partnership with the Iowa Chapter of the American Academy of Pediatrics.			X	X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
All local CH contract agencies now have a dental hygienist serving as an I-Smile coordinator. The agencies are implementing action plans that focus on the strategies of partnerships and planning, local board of health linkage, and screenings and risk assessments. OHB staff sponsor quarterly coordinator meetings to assist in I-Smile system development. Meetings included presentations on public health core functions, health literacy and cultural competency. The meetings also allow coordinators to share best practice examples.

In response to Medicaid policy changes, OHB staff created presentations for I-Smile coordinators to train non-dental professional staff. The presentations include information on the importance of oral health, how to provide oral screenings, how to apply fluoride varnish and oral health education topics.

A physician training pilot project funded through the State Oral Health Collaborative Systems grant is being replicated throughout the state. I-Smile coordinators are partnering with physicians and other non-dental health care providers, providing trainings on oral screenings and fluoride varnish applications for children age three and younger. The coordinators are distributing the I-Smile Screening Guides through these trainings. In addition, the Iowa chapter of the American Academy of Pediatrics offered video conference trainings.

c. Plan for the Coming Year
INFRASTRUCTURE-BUILDING SERVICES: OHB staff will continue to work through the I-Smile initiative to build a dental home system. This includes providing support and information for the Medical Home System Advisory Council, providing technical support and training for I-Smile Coordinators, and collaborating with the Head Start State Collaboration Office and the Head Start dental home project. Primary care and pediatric medical practitioners will be a focus of training efforts to build a larger network of providers of oral health services for children ages 3 and under.

Following the first year of the school dental screening requirement, OHB staff will review the school audit report data. These data will include county and school district information about treatment needs and provider types, and will help determine if the screenings are impacting young children's access to preventive and treatment services and demonstrate areas of need for focusing new oral health efforts for preschool children.

Enhancements to the CAReS electronic health record will allow OHB staff to monitor and assess dental disease risk levels and oral health status of those clients served by local CH agencies. The assessment will assist the OHB in program planning. Targeted Oral Health Service Systems grant activities will include oral health status surveillance on children within either WIC or child care settings, as part of baseline measures for children age 5 and under.

POPULATION-BASED, ENABLING AND DIRECT SERVICES: Health promotion through the TOHSS grant may include public service announcements, being tested in FFY09. Through the PSAs and other materials -- including an I-Smile Web site - the OHB hopes to impact parents' and health care providers' understanding of the importance of early and regular care for children, beginning by the age of 1.

As part of the state's new school screening requirement, there will be a focus on providing schools and preschools oral health education materials to be used at kindergarten roundups and

oral health promotion efforts targeting parents of preschoolers.

I-Smile Coordinators will continue to enhance care coordination activities within Title V programs to assist families in accessing dental services. Local CH contract agencies will also be encouraged to provide gap-filling preventive services as part of the I-Smile dental home.

State Performance Measure 9: *Rate (per 1,000 births) of infant deaths due to prematurity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			3.2	3.1	3.1
Annual Indicator		3.2	3.0	3.0	3.2
Numerator		127	121	120	128
Denominator		39255	40564	40488	40221
Data Source					Vital Statistics
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.1	3	2.9	2.8	2.7

Notes - 2008
2008 Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from provisional 2007 Vital Statistics provisional data.

Notes - 2006
Data were obtained from provisional 2006 Vital Statistics data.

a. Last Year's Accomplishments
The FFY08 performance objective of 3.1 was not met. Vital statistics provisional data show that the rate per 1,000 births of infant deaths due to prematurity was 3.2 in 2008. Three factors that may have contributed to the increase in this indicator: 1) uninsured women, 2) smoking rate of pregnant women and 3) late preterm (34-37 weeks) births as outlined in the March of Dimes Premature Birth Report Card.

INFRASTRUCTURE BUILDING SERVICES: Local MCH contract agencies provided education and support to all maternal health clients on reducing risk factors for preterm birth including encouraging tobacco cessation, stress reduction, importance of medical home, early entry prenatal care and the importance of prenatal care.

Based on evidence linking periodontal disease and smoking with premature delivery, tobacco cessation and motivational counseling training was conducted. The I-Smile dental hygienists were included in this training. Medicaid approved a new billing code for dental hygienists working with maternal health clients to be able to bill for tobacco cessation counseling as it relates to oral health. This has resulted in an increase in the counseling provided to pregnant women. Medicaid covered the cost of some nicotine replacement therapy for clients, including pregnant women with approval from their physician or midwife. Quit line Iowa provided free telephone counseling for smokers who wanted to quit.

In collaboration with the University Of Iowa Carver School Of Medicine and the March of Dimes,

IDPH held a Summit on Prevention of Prematurity in November for parents of preterm newborns and health care professionals. Eighty health care professionals and parents attended this conference.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to participate in the Prevention of Prematurity Summit for health care providers.				X
2. Host a physician based training on maternal depression and the effect to infants.				X
3. Continue to provide trainings to local MCH agencies on smoking cessation.			X	X
4. Continue to promote the partnership with the Division of Tobacco, Planned Parenthood and ACOG.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: IDPH staff continue to provide training for local MCH contract agencies and family planning agencies assessing for tobacco use, advising them to quit and referring women to Quitline Iowa. A Maternal Health Taskforce within IDPH and Iowa Medicaid Enterprise (IME) is collaborating efforts to reduce smoking among pregnant Medicaid women. This task force meets quarterly.

Local MH agencies received training on tobacco cessation counseling and on the rising preterm birth rate in Iowa. The training also included information on free nicotine replacement therapy available to Medicaid members in Iowa. The Quit line Iowa developed a specific tobacco cessation program specifically for pregnant and postpartum women.

The winter issue of the Iowa Perinatal Letter was titled The Rising Pre-term Delivery Rate in Iowa -- Three Things We Can Do Now. The newsletter is mailed to all health care providers in Iowa who deliver babies and is also posted on the IDPH Web site at the following site: http://www.idph.state.ia.us/hpcdp/common/pdf/perinatal_newsletters/perinatal_jan_feb_mar_08.pdf

POPULATION-BASED SERVICES: Legislation was passed in the 2008 General Assembly requiring bars and restaurants to ban smoking in Iowa. This should decrease effects of second hand smoke, especially for pregnant women who work in bars or restaurants.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: Continue to partner with the IDPH Division of Tobacco Use Prevention and Control, ACOG, Planned Parenthood and Title X grantees will continue to partner to reduce tobacco use among women of child bearing age.

The Maternal Health Taskforce will continue to meet quarterly. The taskforce will track Medicaid birth outcomes including data on the number of pregnant Medicaid women in Iowa who smoke.

The taskforce will explore collaborative efforts to reduce smoking in women of childbearing age.

The Statewide Perinatal Team will continue to reinforce three concepts identified in the Iowa Perinatal Letter The Rising Pre-term Delivery Rate in Iowa -- Three Things We Can Do Now: 1) Adopt a zero tolerance policy for any elective delivery before 39 weeks based on good OB dating, 2) Utilize progesterone therapy in women who have a history of pre-term birth and 3) Increase efforts to diminish exposure to cigarette smoke, both primary smoke and second hand smoke.

The Bureau of Family Health will explore further collaboration with March of Dimes in the Prevention of Prematurity Summit for health care providers for the fall of 2010.

State Performance Measure 10: *Number of professionals trained on the use of appropriate maternal depression screening tools and the available referral resources.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			600	200	1500
Annual Indicator					
Numerator		150	150	1440	784
Denominator		1	1	1	1
Data Source					Maternal Depression trainings
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	750	750	750	750	750

Notes - 2008
2008 Data were obtained from Maternal Depression trainings that were conducted in 2008. The objective was not met in part because approximately half of the trainers did not submit evaluation data from their trainings. Staff are working with trainers to make sure evaluation data is completed.

Notes - 2007
Data were obtained from Maternal Depression trainings that were conducted in 2007.

Notes - 2006
Data were obtained from Maternal Depression trainings that were conducted in 2006.

a. Last Year's Accomplishments
The FFY08 performance objective of 1500 was not met. Data from Maternal Depression trainings conducted in 2008 show that 784 professionals were trained on the use of appropriate maternal depression screening tools and the available referral resources. The objective was not met in part because approximately half of the trainers did not submit evaluation data from their trainings. Staff are working with trainers to make sure evaluation data is completed.

INFRASTRUCTURE BUILDING SERVICES: Train the trainer (TTT) has completed its third round of training. There are now 47 individuals for public health and primary care that have successfully completed the Train the Trainer program. They are now training others on maternal depression screening. The Support and Training to Enhance Primary Care for Postpartum Depression (STEP-PPD) a web based training for health care professionals was evaluated for effectiveness. Training via distance learning through the Learning Management System will be completed by

Fall of 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to promote the Maternal Depression train the trainer in partnership with the University of Iowa Center for Depression and Clinical Research.				X
2. Provide support for local maternal depression trainings.			X	X
3. Continue to work on the Perinatal Depression Project.				X
4. Collaborate with Early Childhood Iowa, 1st Five, and Iowa Medical Home Initiative.				X
5. Through the Center of Depression and Clinical Research, provide a newsletter on maternal depression.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES: Funding was secured for the fourth round of TTT. Twenty five additional trainers will be certified to provide training at the local level. The STEP-PPD evaluation is completed, and is available online to train medical professionals. The program Web site is www.step-ppd.com and it is available to providers free of charge.

An online consultation service provides free mental health consultation with psychiatrists at the University of Iowa for family practice and obstetric providers in the state. The services can be found on our web site www.beyondtheblues.info. A resource list of mental health providers in all 99 Iowa counties was developed and added to the perinatal depression Web site www.beyondtheblues.info.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES: IDPH will distribute over 1,000 pocket guides from the STEP- PPD training to primary care professionals who deliver babies in Iowa and mental heath professionals. The content was developed by Michael O'Hara PhD (Psychologist) and Scott Stuart M.D. (Psychiatrist) from the University of Iowa Center for Depression and Clinical Research. Medication guides will also be posted to the web site.

Because lack of insurance can be a barrier to postpartum women receiving treatment for depression IDPH will meet with DHS to explore improved insurance coverage for Mental Health. Most pregnant women loose Medicaid benefits 6 weeks after delivery we will propose a wavier for women needed Mental Health care to continue Medicaid for one year postpartum to cover needed medication and treatment.

E. Health Status Indicators

Introduction
The nine Health Status Indicators (HSI) provide critical information about the capacity of Iowa's MCH health status for the Title V populations served. Iowa made progress on the HSI in recent years, as indicated on forms 20. There are several reasons for the improvements seen in the HSI measures.

State agency coordination activities, such as those described in the previous section of this application, had a positive impact on the capacity of IDPH to progress on specific initiatives. For example, the maternal health program, local maternal health agencies and local maternity providers have worked together to increase access to maternity services throughout the state. Ongoing partnerships between IDPH and other state departments also had a positive impact.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.0	7.2	6.9	6.8	6.7
Numerator	2692	2829	2814	2795	2683
Denominator	38355	39255	40564	40835	40221
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

Narrative:
Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. In 2004 the percentage was 7.0 and in 2008 the percentage is 6.7. The LBW singleton percent for 2004 was 5.3 and 4.9 for 2008. Over the past five years there has been a slight decrease each year in LBW births and the singleton LBW births.

Data on this indicator are reviewed annually to identify trends and areas of concern. Program staff uses the data to identify emerging strategies that can be used to decrease the percentage of LBW infants. Some strategies include tobacco cessation training for local MH contract agencies and partners. The Tobacco cessation training team includes ACOG representatives, Planned Parenthood, Bureau of Family Health and the Division of Tobacco Control. The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are

receiving the appropriate level of care.

Additionally, as noted in Health System Capacity Indicator 5A, access to smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits was made available to Medicaid eligible pregnant women in response to data which reflected a high proportion of women who reported that they smoked during pregnancy. This policy change took effect January 2008. Evaluation of this strategy will be conducted as a component of the Medicaid/Birth Certificate match.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.3	5.4	5.3	5.1	4.9
Numerator	1946	2047	2058	1995	1913
Denominator	37039	37883	39152	39369	38737
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

Narrative:
Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. In 2004 the percentage was 7.0 and in 2008 the percentage is 6.7. The LBW singleton percent for 2004 was 5.3 and 4.9 for 2008. Over the past five years there has been a slight decrease each year in LBW births and the singleton LBW births.

Data on this indicator are reviewed annually to identify trends and areas of concern. Program staff uses the data to identify emerging strategies that can be used to decrease the percentage of LBW infants. Some strategies include tobacco cessation training for local MH contract agencies and partners. The Tobacco cessation training team includes ACOG representatives, Planned Parenthood, Bureau of Family Health and the Division of Tobacco Control. The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are receiving the appropriate level of care.

Additionally, as noted in Health System Capacity Indicator 5A, access to smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits was made available to Medicaid eligible pregnant women in response to data which reflected a high proportion of women who reported that they smoked during pregnancy. This policy change took effect January 2008. Evaluation of this strategy will be conducted as a component of the Medicaid/Birth Certificate match.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	1.4	1.3	1.3	1.2
Numerator	506	543	509	544	501
Denominator	38355	39255	40564	40835	40221
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

Narrative:
Very low birth weight percentage in Iowa has remained virtually the same with minor decreases and increases over the past five years. The VLBW went from 1.3 percent in 2004 to 1.2 percent in 2008. The singleton VLBW was 1.0 percent in 2004 to .9 percent in 2008. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.0	1.0	1.0	0.9	0.9
Numerator	369	377	374	357	346
Denominator	37039	37883	39152	39369	38737
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics data.

Notes - 2006
Data were obtained from 2006 Vital Statistics data.

Narrative:
Very low birth weight percentage in Iowa has remained virtually the same with minor decreases and increases over the past five years. The VLBW went from 1.3 percent in 2004 to 1.2 percent in 2008. The singleton VLBW was 1.0 percent in 2004 to .9 percent in 2008. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	11.1	7.3	14.6	7.5	8.7
Numerator	63	40	85	44	51
Denominator	569387	547627	581387	583316	586749
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
The data were obtained from 2007 Vital Statistics data.

Notes - 2006
The data were obtained from 2006 Vital Statistics data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate due to unintentional injuries among children ages 14 and young is 8.7 per 100,000. Since 2004, annual rates demonstrated noticeable fluctuations, but no clear trends. In 2004 the rate was 11.1, 2005- 7.3, 2006 -14.6 and 2007- 7.5. The death rate for unintentional injuries among children ages 14 and younger due to motor vehicle crashes went from 6.7 per 100,000 in 2004 to 2.7 per 100,000 in 2008. The death rate from unintentional injuries due to motor vehicle crashes among youth ages 15 through 24 was 21.8 per 100,000 in 2004 to 18.7 per

100,000 in 2008. In 2005, the state saw a drastic increase to 35.8 per 100,000.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.7	4.4	2.1	4.6	2.7
Numerator	38	24	12	25	16
Denominator	569387	547627	581387	543571	586749
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006
The data were obtained from 2006 Vital Statistics data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate due to unintentional injuries among children ages 14 and young is 8.7 per 100,000. Since 2004, annual rates demonstrated noticeable fluctuations, but no clear trends. In 2004 the rate was 11.1, 2005- 7.3, 2006 -14.6 and 2007- 7.5. The death rate for unintentional injuries among children ages 14 and younger due to motor vehicle crashes went from 6.7 per 100,000 in 2004 to 2.7 per 100,000 in 2008. The death rate from unintentional injuries due to motor vehicle crashes among youth ages 15 through 24 was 21.8 per 100,000 in 2004 to 18.7 per 100,000 in 2008. In 2005, the state saw a drastic increase to 35.8 per 100,000.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	21.8	35.8	23.8	26.5	18.7
Numerator	96	155	105	115	81
Denominator	440974	433548	440689	433507	432262
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data were obtained from 2008 Vital Statistics provisional data.

Notes - 2007
Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006
The numerator data were obtained from 2006 Vital Statistics data and the denominator data were obtained from 2005 Census data.

Narrative:
Unintentional injuries are the result of about half of all the deaths to Iowa residents ages 1-14. The death rate due to unintentional injuries among children ages 14 and young is 8.7 per 100,000. Since 2004, annual rates demonstrated noticeable fluctuations, but no clear trends. In 2004 the rate was 11.1, 2005- 7.3, 2006 -14.6 and 2007- 7.5. The death rate for unintentional injuries among children ages 14 and younger due to motor vehicle crashes went from 6.7 per 100,000 in 2004 to 2.7 per 100,000 in 2008. The death rate from unintentional injuries due to motor vehicle crashes among youth ages 15 through 24 was 21.8 per 100,000 in 2004 to 18.7 per 100,000 in 2008. In 2005, the state saw a drastic increase to 35.8 per 100,000.

To prevent mortality in these age groups, state and local partners are working with SAFE Kids coalition and many other injury prevention organizations. One strategy example for reducing mortality includes partnering with the Iowa Health System in presenting "Think First! Injury Prevention Program." The program informs youth during school programs about the profound consequences of not wearing seatbelts and encourages safe behaviors.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6,219.0	10,217.2	10,061.1	9,722.9	7,353.9

Numerator	35410	55952	58494	56715	43149
Denominator	569387	547627	581387	583316	586749
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data were obtained from Department of Transportation data.

Notes - 2007
Data were obtained from Department of Transportation data.

Notes - 2006
Data were obtained from Department of Transportation data. The DOT data includes regular diagnosis coes instead of E-code only so numbers for 2006 are higher than in the past years.

Narrative:
Surveillance of unintentional injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Unintentional injuries are often a contributing factor in temporary or permanent disability or poor health. Iowa currently collects the data from the Department of Transportation database. Since 2005 there has been a slight decrease in the nonfatal injuries to children ages 14 and younger. (10,217/100,000 in 2005 to 7,353/100,000 in 2008)

The unintentional injury rate due to motor vehicle crashes among children ages 14 and younger has remained steady with an increase in 2008 of 303/100,000. The unintentional injury rate due to motor vehicle crashes among youth ages 15 to 24 increased to 1,237/100,000 this year from 1063/100,000 in 2005.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	324.0	240.5	221.7	217.9	303.7
Numerator	1845	1317	1289	1271	1782
Denominator	569387	547627	581307	583316	586749
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data were obtained from Department of Transportation data.

Notes - 2007
Data were obtained from Department of Transportation data.

Notes - 2006
Data were obtained from the Department of Transportation data set.

Narrative:
Surveillance of unintentional injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Unintentional injuries are often a contributing factor in temporary or permanent disability or poor health. Iowa currently collects the data from the Department of Transportation database. Since 2005 there has been a slight decrease in the nonfatal injuries to children ages 14 and younger. (10,217/100,000 in 2005 to 7,353/100,000 in 2008)

The unintentional injury rate due to motor vehicle crashes among children ages 14 and younger has remained steady with an increase in 2008 of 303/100,000. The unintentional injury rate due to motor vehicle crashes among youth ages 15 to 24 increased to 1,237/100,000 this year from 1063/100,000 in 2005.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1,666.4	1,063.3	1,034.1	1,104.9	1,237.2
Numerator	7308	4610	4557	4790	5348
Denominator	438548	433548	440689	433507	432262
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data were obtained from Department of Transportation data.

Notes - 2007
Data were obtained from Department of Transportation data.

Notes - 2006
Data were obtained from the Department of Transportation data set.

Narrative:
Surveillance of unintentional injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Unintentional injuries are often a contributing factor in temporary or permanent disability or poor health. Iowa currently collects the data from the Department of Transportation database. Since 2005 there has been a slight decrease in the nonfatal injuries to children ages 14 and younger. (10,217/100,000 in 2005 to 7,353/100,000 in

2008)

The unintentional injury rate due to motor vehicle crashes among children ages 14 and younger has remained steady with an increase in 2008 of 303/100,000. The unintentional injury rate due to motor vehicle crashes among youth ages 15 to 24 increased to 1,237/100,000 this year from 1063/100,000 in 2005.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	20.0	20.9	21.3	22.1	24.3
Numerator	2061	2132	2259	2349	2582
Denominator	103272	102028	106102	106446	106081
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2007
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2006
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Narrative:
Chlamydia can impact a woman's future fertility and has few recognizable symptoms. The Iowa Department of Public Health's Sexually Transmitted Disease Program is continuing its successful efforts to accomplish state and federal goals. In a rural state like Iowa, the STD program must partner with other groups, agencies, and organizations for the delivery of information and services. The combination of local health departments and a network of local medical providers are the system that controls these diseases.
In the state of Iowa, Chlamydia is reportable to the Iowa Department of Public Health. By Iowa Code, both the physician who ordered the test and the laboratory who processes the specimen are both to report names and other patient demographics. This information is protected by law and cannot be released to anyone other than individuals (disease prevention specialists and county public health communicable disease investigators) who perform partner notification and partner referral. In Iowa, by law, a minor can be tested and treated for a sexually transmitted disease without parental consent. The rate of reported Chlamydia cases for women ages 15 through 19 has remained the same since 2004 with a slight increase in 2008 to 24.3 per 1,000. The rate of reported Chlamydia cases for women ages 20 through 44 increased from 6.0/1,000 in 2004 to 10.2/1,000 in 2006 back to 8.9/1,000 in 2008. A screening pilot project for testing women coming in for pregnancy testing and offered a chlamydia/gonorrhea started in April 2009 through a partnership with IDPH and two local women's health centers in Waterloo and Davenport.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6.0	6.3	10.2	8.0	8.9
Numerator	3014	3131	4933	3817	4187
Denominator	499730	498792	481366	476502	473044
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2007
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Notes - 2006
Data were obtained from the Iowa Department of Public Health STD Prevention Program.

Narrative:
Chlamydia can impact a woman's future fertility and has few recognizable symptoms. The Iowa Department of Public Health's Sexually Transmitted Disease Program is continuing its successful efforts to accomplish state and federal goals. In a rural state like Iowa, the STD program must partner with other groups, agencies, and organizations for the delivery of information and services. The combination of local health departments and a network of local medical providers are the system that controls these diseases.
In the state of Iowa, Chlamydia is reportable to the Iowa Department of Public Health. By Iowa Code, both the physician who ordered the test and the laboratory who processes the specimen are both to report names and other patient demographics. This information is protected by law and cannot be released to anyone other than individuals (disease prevention specialists and county public health communicable disease investigators) who perform partner notification and partner referral. In Iowa, by law, a minor can be tested and treated for a sexually transmitted disease without parental consent. The rate of reported Chlamydia cases for women ages 15 through 19 has remained the same since 2004 with a slight increase in 2008 to 24.3 per 1,000. The rate of reported Chlamydia cases for women ages 20 through 44 increased from 6.0/1,000 in 2004 to 10.2/1,000 in 2006 back to 8.9/1,000 in 2008. A screening pilot project for testing women coming in for pregnancy testing and offered a chlamydia/gonorrhea started in April 2009 through a partnership with IDPH and two local women's health centers in Waterloo and Davenport.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY	Total	White	Black or African	American Indian or	Asian	Native Hawaiian	More than	Other and

TOTAL POPULATION BY RACE	**All Races**		**American**	**Native Alaskan**		**or Other Pacific Islander**	**one race reported**	**Unknown**
Infants 0 to 1	43833	38635	2387	417	1177	70	1147	0
Children 1 through 4	170312	147770	10637	2151	4370	283	5101	0
Children 5 through 9	203135	177939	11815	2442	4968	357	5614	0
Children 10 through 14	203293	181451	10589	1907	4456	267	4623	0
Children 15 through 19	224174	204162	10107	2030	4016	263	3596	0
Children 20 through 24	220489	203161	8401	1803	4427	250	2447	0
Children 0 through 24	1065236	953118	53936	10750	23414	1490	22528	0

Notes - 2010

Narrative:
Ninety-four percent of the population is white; however, racial and cultural diversity continues to increase at a gradual, yet steady rate. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.2 percent in the 2008 estimate. Birth data also indicate an increase in Hispanic population. Approximately 240,041 children are five or younger and make up about 8.0 percent of the total population. Of the children between the ages of zero and five, 8.9 percent are children of Hispanic origin and there are an estimated 8.9 percent of children who have a special health care need.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	38979	3236	0
Children 1 through 4	150230	12339	0
Children 5 through 9	182231	13418	0
Children 10 through 14	185881	11979	0
Children 15 through 19	209692	10133	0
Children 20 through 24	208516	9499	0
Children 0 through 24	975529	60604	0

Notes - 2010

Narrative:
Ninety-four percent of the population is white; however, racial and cultural diversity continues to increase at a gradual, yet steady rate. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.2 percent in the 2008 estimate. Birth data also indicate an increase in Hispanic population. Approximately 240,041 children are five or younger and make up about 8.0

percent of the total population. Of the children between the ages of zero and five, 8.9 percent are children of Hispanic origin and there are an estimated 8.9 percent of children who have a special health care need.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	38	16	10	1	0	0	0	11
Women 15 through 17	1024	729	110	11	8	1	30	135
Women 18 through 19	2565	2042	206	27	20	3	63	204
Women 20 through 34	32339	27958	1226	176	687	41	217	2034
Women 35 or older	4236	3656	110	11	146	1	12	300
Women of all ages	40202	34401	1662	226	861	46	322	2684

Notes - 2010

Narrative:
In 2008 data, 86 percent of the live births were born to White mothers, eight percent to Hispanic mothers, four percent to Black mothers and two percent to Asian mothers. In 2008, live births to Hispanic women made up 8.2 percent of all births, double the population proportion (4.2 percent) in the same year.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	27	10	1
Women 15 through 17	824	193	7
Women 18 through 19	2222	314	29
Women 20 through 34	29468	2451	420
Women 35 or older	3837	322	77
Women of all ages	36378	3290	534

Notes - 2010

Narrative:

In 2008 data, 86 percent of the live births were born to White mothers, eight percent to Hispanic mothers, four percent to Black mothers and two percent to Asian mothers. In 2008, live births to Hispanic women made up 8.2 percent of all births, double the population proportion (4.2 percent) in the same year.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	226	196	27	0	2	0	0	1
Children 1 through 4	54	47	4	0	3	0	0	0
Children 5 through 9	25	22	1	0	2	0	0	0
Children 10 through 14	25	23	1	0	1	0	0	0
Children 15 through 19	102	94	8	0	0	0	0	0
Children 20 through 24	147	136	9	0	1	0	0	1
Children 0 through 24	579	518	50	0	9	0	0	2

Notes - 2010

Narrative:
The death certificate data for children by age group by race is readily available from Vital Statistics as is death certificates data fro children by age group by ethnicity. These data are useful as a tool in public health planning and implementation efforts.
In 2008, there were 579 deaths to childen ages 0-24 with 226 of deaths to infants. White children comprise 89 percent of the deaths to children and Black children comprise 9 percent of the deaths to children. Black infants comprise 12 percent of the deaths to infants. There was a two percent increase in the death rate for Black children (7 percent 20007 and 9 percent in 2008).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	201	25	0
Children 1 through 4	51	3	0
Children 5 through 9	24	1	0
Children 10 through 14	25	0	0
Children 15 through 19	97	5	0
Children 20 through	141	6	0

24			
Children 0 through 24	539	40	0

Notes - 2010

Narrative:
The death certificate data for children by age group by race is readily available from Vital Statistics as is death certificates data fro children by age group by ethnicity. These data are useful as a tool in public health planning and implementation efforts.
Hispanic children comprise 7 percnet of the deaths to children. Hispanic infants comprise 12 percent of the of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age. This is a decrease from 2007 (16 percent).

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	844747	749957	45535	8947	18987	1240	20081	0	2007
Percent in household headed by single parent	29.3	26.6	73.9	78.7	4.7	0.0	60.0	0.0	2006
Percent in TANF (Grant) families	100.0	44.3	17.3	1.1	0.8	0.0	0.0	27.8	2008
Number enrolled in Medicaid	191679	109906	19665	1643	1880	0	0	58585	2008
Number enrolled in SCHIP	19803	15167	636	111	180	19	0	3690	2008
Number living in foster home care	7402	5316	1121	147	55	23	147	593	2007
Number enrolled in food stamp program	115115	63441	15317	1120	955	0	0	34282	2008
Number enrolled in WIC	60408	48281	6319	291	1047	0	3776	694	2008
Rate (per 100,000) of juvenile crime arrests	3017.0	2468.0	10526.0	3508.0	1456.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.9	2.5	6.1	3.2	2.6	0.0	0.0	0.0	2008

Notes - 2010
2006 was last available data

Narrative:
Data for this year shows an increase in the number of children ages 0 to 19 (about 44,000), the number enrolled in Medicaid (about 20,000), hawk-i (SCHIP) (around 500), food stamps (about 13,000) and WIC (around 7,500). The percentage of high school drop-outs continues to slightly increase each year (2.1 in 2007 to 2.9 in 2008).

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	767013	51105	0	2007
Percent in household headed by single parent	27.8	44.3	0.0	2006
Percent in TANF (Grant) families	91.2	8.8	0.0	2008
Number enrolled in Medicaid	191679	20166	0	2008
Number enrolled in SCHIP	19803	1391	0	2008
Number living in foster home care	5875	514	1013	2007
Number enrolled in food stamp program	115115	11150	0	2008
Number enrolled in WIC	59714	17764	694	2008
Rate (per 100,000) of juvenile crime arrests	2907.0	3294.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.7	6.1	0.0	2008

Notes - 2010
2006 represents latest available data.

Narrative:
Data for this year shows an increase in the number of children ages 0 to 19 (about 44,000), the number enrolled in Medicaid (about 20,000), hawk-i (SCHIP) (around 500), food stamps (about 13,000) and WIC (around 7,500). The percentage of high school drop-outs continues to slightly increase each year (2.1 in 2007 to 2.9 in 2008).

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	330192
Living in urban areas	242767
Living in rural areas	325650
Living in frontier areas	200167

Total - all children 0 through 19	768584

Notes - 2010
2008 shows a total of 803,544, but the data cannot be broken down by area in 2008

Narrative:
There about 43 percent of Iowa children living in metro areas. The breakdowns of geographic residency include: 32 percent urban, 42 percent rural and 26 percent frontier.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3002555.0
Percent Below: 50% of poverty	3.7
100% of poverty	6.6
200% of poverty	17.5

Notes - 2010
Breakdown of poverty levels is not available for 2008 data

Narrative:
Data show that children are more likely to live in poverty in Iowa with 4.8 percent of children ages 0 to 19 in households with incomes >50% FPL compared to 3.7 for all of Iowans; 9.9 percent of children ages 0 to 19 in households with incomes below 100% FPL compared to 6.6 percent; 22.3 percent of children ages 0 to 19 in households with incomes below 200% FPL compared to 17.5 percent.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	803544.0
Percent Below: 50% of poverty	4.8
100% of poverty	9.9
200% of poverty	22.3

Notes - 2010
Breakdown of poverty level is not available for 2008 data

Narrative:
Data show that children are more likely to live in poverty in Iowa with 4.8 percent of children ages 0 to 19 in households with incomes >50% FPL compared to 3.7 for all of Iowans; 9.9 percent of

children ages 0 to 19 in households with incomes below 100% FPL compared to 6.6 percent; 22.3 percent of children ages 0 to 19 in households with incomes below 200% FPL compared to 17.5 percent.

F. Other Program Activities

Other Program Activities:

The MCH Title V program has been extensively involved in providing leadership for changes in the service delivery system for children including but not limited to Community Empowerment Areas, the State Children's Health Insurance Program, Early Hearing Detection and Intervention, Newborn Metabolic Screening, Early ACCESS (IDEA, Part C), and the Iowa Medical Home Initiative. A list of formal and informal organizational relationships is located in the attachment for Organizational Structure section III-C. /2009/ Contracts and memorandums of agreement are found in the attachment for this section, IV-F. //2009//

Family Planning activities are coordinated with the IDPH Family Planning Program and the Family Planning Council of Iowa, the Title X contractor for the state.

Following are other Child Health Specialty Clinic program activities:

1. State and regional staff are involved with planning and operation of Community Empowerment Areas.

2. Staff contribute to course development and teaching for the University of Iowa College of Public Health MCH focus track students and other graduate students. ***/2010/ Over the last two years, staff have also given a lecture/discussion on social determinants of health to first- and second-year University of Iowa medical students enrolled in an elective class. //2010//***

3. Staff participate in planning and providing experiences for leadership training in the ILEND (Iowa Leadership Education in Neurodevelopmental Disorders) program. The CHSC Director is the co-director of the ILEND grant.

4. CHSC, when requested, works with the Iowa Departments of Human Services and Public Health to assure quality care for CYSHCN enrolled in Medicaid and SCHIP Programs.

5. Staff participate in planning and field-testing new approaches to delivering physical and behavioral health care services and consultation to community-based sites using telemedicine techniques. /2007/ A one-year grant from the Iowa Department of Public Health to CHSC focuses on telehealth and requires a review of technology use; assessment of telehealth training needs; pilot testing of training modules; and submission of a summary report with recommendations. /2007/

6. Staff lead and participate in constructing and implementing the long-range statewide public health blueprint, "Healthy Iowans 2010", which is modeled after "Healthy People 2010".

7. CHSC is represented on the College of Public Health "Community Health Partners Advisory Committee" that seeks to provide training and field experiences to new public health professionals.

8. Staff direct a SPRANS grant project to integrate systems for CYSHCN with emphasis on the medical home, care coordination for primary care practices, and early childhood screening.

9. Staff lead an MCHB-supported project to improve the statewide system of early hearing detection and intervention for newborns and infants.

10. Staff participate in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.

11. Staff participate in a Department of Human Services effort to assure healthy child mental development by improving early childhood screening practices among primary care providers.

12. Staff participate in several IDEA Part C program planning and quality assurance activities. /2007/ Staff also function as "service coordinators" for selected children enrolled in Part C who have complex medical problems. /2007/ ***/2010/ ARRA stimulus funds granted to the Part C program extend CHSC's ability to provide both service coordination and nutrition consultation to enrolled 0-3 year olds. ARRA funds to Part C also support CHSC staff investigating the roles of social determinants of health, as well as various home-based toxic exposures on early childhood development. //2010//***

13. Staff serve on a Governor appointed multidisciplinary collaborative work group to develop a statewide system of mental health services for children.

14. Staff serve in an advisory capacity to the Department of Public Health data integration initiative.

/2007/ 15. Staff serve in an advisory capacity for the new Iowa Department of Public Health's initiative to improve the "provider safety net" (community health centers, rural health clinics, and free medical clinics) for medically underserved Iowans. /2007/ ***/2010/ This initiative has expanded to include a special emphasis on investigating the fit between the medical home model and various safety net providers, especially free medical clinics. //2010//***

/2008/ 16. CHSC is represented on the Center for Disabilities and Development "Community Partners Advisory Committee" which seeks to improve community outreach, advocacy, and services to Iowa's citizens with disabilities.

17. CHSC leads the clinical operations portion of a new multi-partner SAMHSA-supported system development effort for children with severe emotional disorder (SED). /2008/

/2009/ 18. Staff partner with the Iowa Department of Public Health and the Univ of Iowa Public Policy Center to prepare, interpret, and disseminate the quintennial Iowa Child and Family Household Health Survey. //2009//

/2010/ 19. Staff partner with the Iowa Department of Public Health and other epidemiologists to publish a research paper investigating the associations between various characteristics and a state's success in providing transition services to adolescents with special health care needs. //2010//

/2010/ 20. The CHSC Regional Autism Services Program is increasingly involved in promoting and training health care providers and educators in early detection and intervention strategies for children with autism and other disorders on the autism spectrum. //2010//

/2010/ 21. CHSC continues to support increasing family involvement at all levels of the MCH pyramid. Important recent expansions include: initial leadership on Iowa's Family-to-Family Health Information Center project (with planned leadership transition to a family-driven entity); more intensive family-led advocacy efforts fueled by real life family stories of Iowa's CSHCN; increasing competency among family members functioning as program-

specific (e.g. Medicaid waiver and Part C) care coordinators; and brokering culturally competent connections between the Part C program and eligible Hispanic families. //2010//

An attachment is included in this section.

G. Technical Assistance

The Bureau of Family Health is requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2006 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis of the early childhood section. This technical assistance will help the Early Care, Health, and Education System with population based data for four of the system indicators in Iowa's Early Childhood Iowa Strategic Plan.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a plenary speaker at the 2006 Public Health Conference. The plenary session will focus on capacity building within the public health system. The annual Public Health Conference will be held March 28-29, 2006 in Ames, Iowa.

/2007/ The Bureau of Family Health is requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2005 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis of the child health section. This technical assistance will help provide data for the Maternal and Child Health Title V Block Grant application.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a plenary speaker at the 2007 Public Health Conference. The plenary session will focus on capacity building within the public health system. The annual Public Health Conference will be held in April 4-5, 2007 in Ames, Iowa.

BFH is also requesting technical assistance from a national consultant, Kay Johnson, to provide expertise for child health policy and system change that will focus on the private medical community. IDPH will bring together partners from Early Childhood Iowa, Iowa Medical Home Initiative, Child Health Speciality Clinics, Healthy Mental Development Initiative, Early ACCESS, Community Empowerment, local maternal and child health agencies, and the Iowa Chapters of the American Academy of Pediatrics and Family Practice Academy. /2007/

/2008/ The Bureau of Family Health is requesting technical assistance to support an expert consultant from Syracuse, New York on cost reporting for maternal and child health services. The technical assistance will focus on how local MCH agencies need to develop skills in determining the cost of direct care and enabling services. This will promote provision of cost effective services and support funding requests and third party reimbursement.

BFH is also requesting expert consultation to medical and health care staff to advance the development of systems of care that support developmental screening and includes social emotional development and a medical home for all children.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a speaker at a statewide conference for local based MCH providers. The plenary session will focus on capacity building within the public health system. /2008/

/2009/ The Bureau of Family Health (BFH) and Child Health Specialty Clinics (CHSC) are requesting expert consultation to medical and health care staff to advance the development of

systems of care that support developmental screening and includes social emotional development and a medical home for all children.

BFH and CHSC are also requesting technical assistance to pay the honorarium for a speaker at a statewide conference for local based MCH providers. The plenary session will focus on the diffusion of innovation theory.
BFH and CHSC are also requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2005 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis for the 2010 MCH needs assessment.

The BFH is also requesting technical assistance to support follow-up cost reporting for maternal and child health services. The technical assistance will also focus on cost reporting for child care nurse consultants.

The BFH is also requesting technical assistance to conduct an evaluation of the professional development system for health and safety consultation services. IDPH would like to contract with Dr. Jonathan Kotch from the National Training Institute for Child Care Health Consultation.

CHSC is requesting technical assistance to strategize inclusion of the adolescent transition national Title V CSHCN outcome as a more intensively addressed priority in CHSC's program implementation plans. For several years, competing priorities have resulted in under emphasis on the transition-related outcome. Technical assistance would ideally come from another state Title V CSHCN Program that has successfully addressed the transition planning and services outcome priority. /2009/

/2010/ The Bureau of Family Health (BFH) and Child Health Specialty Clinics (CHSC) are requesting technical assistance to support a statewide speaker at the Early Childhood Off to a Good Start conference to advance policy work related to improving social determinants for the early childhood system. BFH and CHSC are also requesting TA to support a statewide speaker at a statewide conference for state and local level public health providers. The speaker would advance the core public health functions and public health modernization.

BFH and CHSC are also requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2005 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis for the 2010 MCH needs assessment. //2010//

V. Budget Narrative

A. Expenditures

See Forms, 3, 4, and 5
Form 3, State MCH Funding Profile, shows a federal allocation expenditure of $7,371,735. With the exception of infant health category, budget and expenditures varied by less than eight percent. The infant health expenditures varied from budget by 37 percent. This is due to changes in the contract for services for neonatology consultation, which was decreased from $55,000 to $15,500. In addition, the proportion of infants served by local Child Health agencies were less than expected. In both instances, this additional amount was expended in the child health category. Contracts with CHSC for MCH Block Grant funds are written for two-year contract periods. Consequently, federal funds not expended in year one of this contract do not meet the DPH Fiscal Bureau's definition of unobligated funds. Therefore, they are not included in the reported unobligated balance.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2004 in the amount of $15,782,119. Of this amount, $8,488,083 was funded by federal Title V. The state match is reported at $5,225,941. This exceeds both the state match requirement and the maintenance of effort requirement. Federal Title V funds expended for infant and child health primary and preventive care was $3,235,323 or 38 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $2,984,475 or 35 percent of the federal block grant funds expended for the year. Administration expenditures of $391,678 represent four percent of the federal Title V amount.

Expenditures for FFY04 exceed Block Grant budgeted amounts. This can be attributed to a decrease in state funds appropriated by the General Assembly. Other variances are explained by efforts to maximize the use of other funding sources and recognize Title V as the payor of last resort. In the attachment, Figure 1 depicts the distribution of federal Title V expenditures by types of individuals served.

In the attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows a continual gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state.

/2007/See Forms, 3, 4, and 5
Form 3, State MCH Funding Profile, shows a federal allocation expenditure of $6,669,050. With the exception of infant health category, budget and expenditures varied by less than eight percent. The maternal health expenditures varied from budget by 26 percent. This is due to increases in the number of pregnant women served.

An unobligated amount of $1,116,348 was used from the FFY 04 allocation.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2005 in the amount of $13,883,988. Of this amount, $6,669,050 was funded by federal Title V. The state match is reported at $5,086,166. This exceeds both the state match requirement of $5,001,788 and the maintenance of effort requirement of 5,035,775. Federal Title V funds expended for infant and child health primary and preventive care was $2,580,283 or 39 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special

health care needs is reported at $2,205,909 or 33 percent of the federal block grant funds expended for the year. Administration expenditures of $493,796 represent seven percent of the federal Title V amount.

The attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows a continual gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2004 -- June 30, 2005 There are no findings in the 2005 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. /2007/

/2008/See Forms, 3, 4, and 5
Form 3, State MCH Funding Profile, shows $6,774,579 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 05 award. Due to a decrease in the state's award for FFY 06, carry forward funds were necessary to maintain community-based programs at current levels for maternal health, child health and children with special needs. Administration expenditures were 13 percent under budget due to staff vacancies.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2006 in the amount of $14,224,632. Of this amount, $6,774,579 was funded by federal Title V. The state match is reported at $5,360,295. This exceeds both the state match requirement of $5,080,934 and the maintenance of effort requirement of $5,035,775. Federal Title V funds expended for infant and child health primary and preventive care was $2,524,401 or 37 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $2,314,898 or 34 percent of the federal block grant funds expended for the year. Administration expenditures of $429,603 represent seven percent of the federal Title V amount.

The attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows a progressive, gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state partnership.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2005 to June 30, 2006. There are no findings in the 2006 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. /2008/

/2009/See Forms, 3, 4, and 5
Form 3, State MCH Funding Profile, shows $7,599,309 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 06 award. Due to a decrease in the state's award for FFY 07, carry forward funds were necessary to maintain community-based programs at current levels for maternal health, child health and children with special needs. Administration expenditures were 7 percent under budget due to staff vacancies.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2007 in the amount of $16,809,478. Of this amount, $7,599,309 was funded by federal Title V. The state match is reported at $5,699,923. This exceeds both the state match requirement of $5,080,934 and the maintenance of effort requirement of $5,035,775. Federal Title V funds expended for infant and child health primary and preventive care was $2,625,990 or 35 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $3,054,066 or 40 percent of the federal block grant funds expended for the year. Administration expenditures of $429,011 represent five percent of the federal Title V amount.

The attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to infrastructure continue to increase for MCH compared to the proportional of funds directed to direct services. For CHSC they have experienced a significant increase in Title V expenitures for direct care and exceeded budgeted numbers. Additionally CHSC received state appropriations for High Risk, Hemophilia, and Cancer that were not known at the time the budget was developed . Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state partnership.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2006 to June 30, 2007. There are no findings in the 2007 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. /2009/

/2010/See Forms, 3, 4, and 5
Form 3, State MCH Funding Profile, shows $6,445,029 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 07 award. Due to a decrease in the state's award for FFY08, carry forward funds were necessary to maintain community-based programs at current levels for maternal health, child health and children with special needs. Administration expenditures were nine percent under budget due to staff vacancies.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY08 in the amount of $17,469,748. Of this amount, $6,445,029 was funded by federal Title V. The state match is reported at $6,325,906. This exceeds both the state match requirement of $4,884,078 and the maintenance of effort requirement of $5,035,775. Federal Title V funds expended for infant and child health primary and preventive care was $2,605,671 or 40 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $1,905,820 or 30 percent of the federal block grant funds expended for the year. Administration expenditures of $548,548 represent nine percent of the federal Title V amount.

The attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to infrastructure continue to increase for MCH compared to the proportional of funds directed to direct services. For CHSC they have experienced a increase in Title V expenditures for direct care and exceeded budgeted numbers. Additionally, CHSC received state appropriations for High Risk, Hemophilia, and Cancer that were not known at the time the budget was developed. Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state partnership.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2007 to June 30, 2008. There are no findings in the 2008 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. //2010//

An attachment is included in this section.

B. Budget

The FFY06 Title V appropriation is projected to be $6,737,839 and a unobligated amount of $830,778 for a total of $7,568,617. As itemized in the attachment, this expected allocation is budgeted as follows: $1,704,248 (23%) for maternal health services; $249,609 (3%) for infant health services; $2,664,646 (35%) for child health services; $2,420,591 (32%) for services to children with special health care needs; and $529,523 (7%) for program administration. These budgeted amounts include unobligated amounts that will be expended in FFY06. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements.

The projected state match is $5,164,902. Iowa continues to exceed the state maintenance of effort of $5,035,775, required since 1989.

Iowa strives to maintain an unobligated balance of approximately $650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, unobligated funds may be used on an as-needed basis to prevent an interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be $14,755,495. This figure, as well as the following breakout by level of services, includes a projected unobligated balance of $830,778 from FFY05.

Direct Services.

The federal-state partnership expenditures for continuation of direct care services are estimated at $3,971,482. This represents approximately 27 percent of the partnership budget. The amount includes 16 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of $1,615,013 or approximately 32 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in

the amount listed for the categories that follow.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $4,145,766 representing 28 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. It also includes 100% of child health local funds and 56 percent of the funding for local maternal health. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT Ill and Handicapped Waiver Services.

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $1,731,221, which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 22 percent of the funding for local child health agencies and 10 percent of local maternal health funds. IDPH projects expenditure of $1,412,639 (plus the related administrative costs of $95,314), and CHSC projects a budget of $223,267 or approximately four percent of the CSHCN budget.

Infrastructure Building Services.
Estimated expenditures for continuing development of core public health functions and system development are $4,907,026 or 33 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 31 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child health systems development consultation. CHSC's budget for infrastructure building services is estimated at $844,399 (17 percent of the CSHCN budget).

/2007/ The FFY07 Title V appropriation is projected to be $6,760,133 based on the 05 award. As itemized in the attachment, this expected allocation is budgeted as follows: $1,409,395 (21%) for maternal health services; $289,940 (4%) for infant health services; $2,175,652 (32%) for child health services; $2,333,591 (35%) for services to children with special health care needs; and $551,554 (8%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements.

The projected state match is $5,370,734. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989.

Iowa strives to maintain an unobligated balance of approximately $650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, unobligated funds may be used on an as-needed basis to prevent an interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be $15,874,543.

Direct Services.
The federal-state partnership expenditures for continuation of direct care services are estimated at $4,231,828. This represents approximately 27 percent of the partnership budget. The amount includes 19 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of $1,772,557 or approximately 35 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in

the amount listed for the categories that follow.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $4,062,622 representing 26 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT Ill and Handicapped Waiver Services.

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $1,835,042, which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 22 percent of the funding for local child health agencies and 11 percent of local maternal health funds. IDPH projects expenditure of $1,562,247 and CHSC projects a budget of $217,639 or approximately four percent of the CYSHCN budget.

Infrastructure Building Services.
Estimated budget for continuing development of core public health functions and system development are $5,745,051 or 36 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health, and EPSDT. This category includes 34 percent of the funding for local child health agencies and 34 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child health systems development consultation. CHSC's budget for infrastructure building services is estimated at $821,892 (16 percent of the CYSHCN budget).
/2007/

/2008/ The FFY08 Title V appropriation is projected to be $6,579,555 based on the FFY06 award. As itemized in the attachment, this expected allocation is budgeted as follows: $1,376,928 (21%) for maternal health services; $295,468 (4%) for infant health services; $2,111,412 (32%) for child health services; $2,190,992 (33%) for services to children with special health care needs; and $604,755 (9%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements.

The projected state match is $6,030,199. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989.

Iowa strives to maintain a carry forward balance of approximately $650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, these funds may be used to minimize the impact of fluctuations in the award amount that might otherwise threat continuity of operations. Additionally, this approach to budgeting prevents interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be $17,767,760.

Direct Services.
The federal-state partnership expenditures for continuation of direct care services are estimated at $4,824,423. This represents approximately 27 percent of the partnership budget. The amount includes 19 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of $1,964,486 or approximately 29 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in

the amount listed for the categories that follow.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $45,487,762 representing 31 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT Ill and Handicapped Waiver Services.

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $1,274,544, which represents 7 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 21 percent of the funding for local child health agencies and 11 percent of local maternal health funds. IDPH projects expenditure of $976,779 and CHSC projects a budget of $237,290 or approximately three percent of the CYSHCN budget.

Infrastructure Building Services.
Estimated budget for continuing development of core public health functions and system development are $6,131,031 or 35 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 34 percent of the funding for local child health agencies and 34 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities. CHSC's budget for infrastructure building services is estimated at $861,159 (13 percent of the CYSHCN budget). /2008/

Budget
/2009/ The FFY09 Title V appropriation is projected to be $6,512,104 based on the FFY06 award. As itemized in the attachment, this expected allocation is budgeted as follows: $1,342,229 (21%) for maternal health services; $291,024 (5%) for infant health services; $2,061,446 (32%) for child health services; $2,190,992 (34%) for services to children with special health care needs; and $626,413 (10%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements.

The projected state match is $5,293,246. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,884,078.

Iowa strives to maintain a carry forward balance of approximately $650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. For FFY09, Iowa will use $260,463 to sustain current efforts.

The total budget for the federal-state partnership is projected to be $18,292,156.

Direct Services.
The federal-state partnership expenditures for continuation of direct care services are estimated at $5,144,406. This represents approximately 28 percent of the partnership budget. The amount includes 17 percent of the funding for local child health agencies and one percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of $2,636,301 or approximately 42 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $4,495,951 representing 25 percent of the partnership budget. This category includes 33 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT Ill and Handicapped Waiver Services.

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $2,329,140, which represents 13 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 17 percent of the funding for local child health agencies and 15 percent of local maternal health funds. IDPH projects expenditure of $2,029,209 and CHSC projects a budget of $237,291 or approximately two percent of the CYSHCN budget.

Infrastructure Building Services.
Estimated budget for continuing development of core public health functions and system development are $6,322,659 or 35 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 33 percent of the funding for local child health agencies and 28 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities. CHSC's budget for infrastructure building services is estimated at $839,160 (5 percent of the CYSHCN budget). /2009/

Budget
/2010/ The FFY10 Title V appropriation is projected to be $6,529,540 based on the FFY08 award. As itemized in the attachment, this expected allocation is budgeted as follows: $1,357,877 (21%) for maternal health services; $292,566 (4%) for infant health services; $2,081,013 (32%) for child health services; $2,191,490 (34%) for services to children with special health care needs; and $606,594 (9%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. In the attachment, Figure 5 illustrates the budget plan for the FFY10 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is $5,057,930. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,897,155.

The total budget for the federal-state partnership is projected to be $16,765,045 Attachment, Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service, as well as population group served.

Direct Services.
The federal-state partnership expenditures for continuation of direct care services are estimated at $4,514,281. This represents approximately 27 percent of the partnership budget. The amount includes 17 percent of the funding for local child health agencies and one percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant projects; and the OB indigent program. CHSC projects a direct care budget of $1,916,739 or approximately 41 percent of the CYSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $3,746,664 representing 22 percent of the partnership budget. This category includes 33 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT Ill and Handicapped Waiver Services.

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $2,058,342, which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 17 percent of the funding for local child health agencies and 15 percent of local maternal health funds. IDPH projects expenditure of $1,837,548 and CHSC projects a budget of $160,134 or approximately one percent of the CYSHCN budget.

Infrastructure Building Services.
Estimated budget for continuing development of core public health functions and system development are $6,445,760 or 38 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 33 percent of the funding for local child health agencies and 28 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities. CHSC's budget for infrastructure building services is estimated at $640,537 (4 percent of the CYSHCN budget).

Other federal funds directed toward MCH include:
State Systems Development Initiative(HRSA/MCHB);
Early Childhood Comprehensive Systems Grant(HRSA/MCHB);
Title X Family Planning;
Early ACCESS (IDEA, Part C);
SAMHSA Integrated Behavioral Health;
Targeted Oral Health System Project(HRSA/MCHB);
Iowa Stillbirth Surveillance Project (CDC);
Iowa Newborn Screening Surveillance Project(CDC);
Iowa Family Participation Project (HRSA/MCHB); and
Early Hearing Detection and Intervention (CDC and HRSA). //2010//

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.